"HIGH-RISK" PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

MARCH 4, 1997

Serial 105–22

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

49–632 CC WASHINGTON : 1998

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON OVERSIGHT

NANCY L. JOHNSON, Connecticut, *Chairman*

ROB PORTMAN, Ohio
JIM RAMSTAD, Minnesota
JENNIFER DUNN, Washington
PHILIP S. ENGLISH, Pennsylvania
WES WATKINS, Oklahoma
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

WILLIAM J. COYNE, Pennsylvania
GERALD D. KLECZKA, Wisconsin
MICHAEL R. MCNULTY, New York
JOHN S. TANNER, Tennessee
KAREN L. THURMAN, Florida

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

"HIGH-RISK" PROGRAMS WITHIN THE JURISDICTION OF THE COMMITTEE ON WAYS AND MEANS

TUESDAY, MARCH 4, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:13 a.m., in room 1100, Longworth House Office Building, Hon. Nancy L. Johnson (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON OVERSIGHT

FOR IMMEDIATE RELEASE
February 13, 1997
No. OV–2

CONTACT: (202) 225-7601

Johnson Announces Hearing on "High-Risk" Programs Within the Jurisdiction of the Committee on Ways and Means

Congresswoman Nancy L. Johnson (R–CT), Chairman, Subcommittee on Oversight of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on "high-risk" programs within the jurisdiction of the Committee on Ways and Means, along with other management issues. The hearing will take place on March 4, 1997, in the main committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be heard from invited witnesses only. Witnesses will include the U.S. General Accounting Office (GAO) and the inspectors general of several departments and agencies. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND

The GAO has issued the third in a series of reports on Federal programs it has identified as high risk because of vulnerabilities to waste, fraud, abuse, and mismanagement. The February 1997 series identifies 25 high-risk areas. Several fall within the jurisdiction of the Committee on Ways and Means, including Internal Revenue Service (IRS) financial management, IRS receivables, filing fraud, IRS Tax Systems Modernization, Customs Service financial management, asset forfeiture programs, the year 2000 problem, information security, Medicare, Supplemental Security Income (SSI), and Superfund program management.

In announcing the hearing, Chairman Johnson stated: "The GAO's high-risk work has zeroed in on programs in which there is the greatest potential for wasting tax dollars. These reports will be tremendously helpful to the Subcommittee in its ongoing oversight of the programs within the Committee's jurisdiction."

FOCUS OF THE HEARING

Improving the efficiency and effectiveness of the IRS, Medicare, and SSI will be a primary focus. However, all of the programs identified by the GAO, as well as the work of the inspectors general, will be examined during the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Tuesday, March 18, 1997, to A.L. Singleton,

Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Oversight office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–225–1904 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman JOHNSON. Good morning. It is a pleasure to convene these hearings on high-risk programs.

Some say the problem with government is that it tries to fix things that are not broken. While this is sometimes true, more often we try to fix things that are broken, where the law is either badly written or the bureaucracy is performing poorly.

In 1990, the GAO, the General Accounting Office, began a series of reviews of Federal programs that are high risk, at high risk of mismanagement and fraud, to enable both the executive and the legislative branches to focus on key problems and to improve the performance of government.

During the time I have been in the Congress, I have worked to turn constituent examples of fraud into legislative and administra-

tive reform. But the process is always slow and complex, and the results not always satisfying.

Fortunately, the General Accounting Office and the Inspectors General throughout the Federal Government are doing the difficult and often thankless task of ferreting out a lot of the problems. I am also pleased that this Committee and Subcommittee have a strong bipartisan tradition of providing constructive oversight of the programs within our jurisdiction.

In December 1990, the Committee launched a comprehensive oversight initiative, holding literally dozens of hearings in this Subcommittee. Beth Vance, who is now the Subcommittee's minority counsel, played a critical role in developing and implementing the oversight initiative, and I very much appreciate her good work in helping us to prepare for today's hearing.

It is, however, unsettling to note that one-third of the 25 high-risk programs identified by the GAO fall within this Committee's jurisdiction. While this fact must be put in the context of the additional fact that this Committee is responsible for nearly all of the government's revenue and about half of the government's spending, it nonetheless poses a tremendous challenge to this Subcommittee. Our job is to understand why certain programs pose a high risk of mismanagement and fraud, and change the law to prevent such abuse.

This morning the GAO will provide us with an overview of the 10 high-risk areas. Six of them—IRS receivables, filing fraud, IRS financial management, tax systems modernization, Customs Service financial management, and asset forfeiture programs—relate to making sure revenues are collected and accounted for.

Two relate to waste, fraud, and abuse, and mismanagement in entitlements—specifically, Medicare, and SSI. And two relate to governmentwide technology issues, information security, and the so-called year 2000 problem.

We will also hear from the Inspectors General of the three departments with programs that fall within the Committee's jurisdiction: Treasury, Labor, and Health and Human Services.

While today's hearing will focus primarily on the problems identified by the GAO and the Inspectors General, in order to determine what actions we need to take legislatively, we will continue to monitor the departments' progress in addressing the issues raised in the high-risk programs.

Welcome. And I would like to yield to my Ranking Member, Mr. Coyne.

Mr. COYNE. Thank you, Madam Chairwoman, and welcome. We have an opportunity today to hear from the experts about many of the program areas within the Ways and Means Committee jurisdiction. For the next several hours, we will receive very important testimony from the U.S. General Accounting Office and the Inspectors General of the Departments of the Treasury, Health and Human Services, and Labor about high-risk programs and related fraud problems facing the Nation.

It is important that the Oversight Subcommittee routinely hold hearings such as the one we are having today, in order to provide oversight review of the large and diverse programs for which we

legislate. Legislating a program is one thing. Making sure the program works is quite another.

I consider it our responsibility to conduct meaningful oversight of all Ways and Means programs, to ensure that our legislative actions are effective. As we proceed over the next several months, I look forward to working with the Members of the Subcommittee and other Subcommittees to follow up on the recommendations made by the witnesses that are here with us today.

I commend the Chairwoman for agreeing to hold these hearings, and appreciate her willingness to include pension plan issues as one of the Subcommittee's first orders of business.

Chairman JOHNSON. Mr. Ramstad, who could not be with us today, asked that his statement be submitted for the record, and that will be ordered, and the statements of any other Members who would like to so submit.

[The statement of Mr. Ramstad follows:]

Statement of U.S. Rep. Jim Ramstad

Madame Chairman, thank you for holding this important hearing on the "high risk" programs under Ways and Means Committee jurisdiction that are vulnerable to waste, fraud and abuse.

Reining in the abuses of "high risk" programs is a continuing struggle, but we are making headway.

For example, the health insurance reform bill we passed last year cracked down hard on the waste, fraud and abuse in the Medicare program.

American taxpayers lose as much as 10% of total health care costs to fraud and abuse—$31 billion annually for Medicare and Medicaid alone.

This is why we established the "Medicare Integrity Program" to increase our ability to prevent payments for fraudulent, abusive or erroneous claims in the Medicare system.

We also required the Health Care Finance Agency to acquire state-of-the-art computer software used by private insurers and to hire private sector companies with proven track records in preventing fraud and abuse. This should result in a net savings of almost $2 billion over the next six years, according to CBO.

Another provision will coordinate federal, state and local law enforcement to combat fraud. We also toughened criminal laws and provided new civil penalties, as an added deterrent.

We *can* find solutions, but we must do more. I hope this hearing will move us toward more common sense measures like these to crack down on waste, fraud and abuse in our "high risk" programs.

Again, Madame Chairman, I commend you for holding this hearing.

Chairman JOHNSON. On the other hand, if any Member would like to make a comment at this time, I will recognize them.

[No response.]

Chairman JOHNSON. Thank you. I welcome the first panel this morning: Gene Dodaro, Assistant Comptroller General, Accounting and Information Management Division, of the U.S. GAO; Lynda Willis, the Director of Tax Policy and Administration Issues, General Government Division of the GAO; Jane Ross, Director of Income Security Issues, Health, Education, and Human Services Division of the GAO; and Leslie Aronovitz, Associate Director, Health Financing and Systems Issues, Health, Education, and Human Services Division of the GAO.

Mr. Dodaro.

STATEMENT OF GENE L. DODARO, ASSISTANT COMPTROLLER GENERAL, ACCOUNTING AND INFORMATION MANAGEMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY DR. RONA STILLMAN, CHIEF SCIENTIST FOR COMPUTERS AND TELECOMMUNICATIONS, AND JOEL WILLEMSSEN, DIRECTOR

Mr. DODARO. Good morning. Madam Chairman, Members of the Subcommittee, we are pleased to be here today to discuss GAO's high-risk work. In the past, since 1990, we've been issuing this list of areas that we feel are vulnerable to waste, fraud, and mismanagement, and we have made hundreds of recommendations directed at solving these problems.

Our latest high-risk series, which comes out as a special publication of booklets, was issued last month. We are now issuing this series at the beginning of each new Congress, to help the Committees focus on areas that need attention, as well as conveying this information to the administration.

In this latest series, our overall conclusion is that progress is being made in these areas. Agencies are taking these problems seriously, working to correct them. Also, some of the progress is due and the credit belongs to the Congress for conducting oversight hearings in many of these areas, and for passing specific legislation directed at some of them: For example, the Health Portability and Accountability Act, which tightens some of the requirements and controls for the Medicare area, which was very important. And there have been some broad-based management reforms passed by the Congress as well, which I am going to talk about in 1 minute.

All of those areas collectively are creating some progress. However, in many areas much remains to be done to implement these reforms and to effectively correct these problems and remove their high-risk designation.

In 1 minute, my colleagues are going to talk about the specific areas the Subcommittee asked us to focus on this morning, which are the IRS problems that are listed in here that Lynda will talk about; Jane will talk about the fact that we are adding the SSI Program to the list new in 1997; and Leslie will report on the progress being made in the Medicare area.

Now, we have taken basically two tacks to try to effectively resolve these problems, and our goal is to get these areas off the list. The first tack has been specific recommendations in each of the individual areas, which the rest of the panel will talk about.

The other tactic that we have tried is to help the Congress shape some broad-based management reform legislation that gets at the underlying causes, some of the common problems underlying these high-risk areas. And there are really three main pieces of legislation that I want to talk about this morning, because those pieces of legislation are important tools that are now available to this Committee to effectively help oversee the agencies under its jurisdiction and to help resolve these problems.

The first are a set of management reforms in the information technology area that were passed in 1995 through the reauthorization of the Paperwork Reduction Act and the passage of the Clinger-Cohen Act in 1996.

This Subcommittee is well aware of some of the problems that have occurred in the tax system modernization in IRS. Unfortunately, these problems that IRS has experienced are not confined to that agency. We also have on our high-risk list the FAA air traffic control modernization effort. We have Defense Information Systems. And we have problems that we have identified in the National Weather Service.

The Federal Government's track record in bringing online information technology projects is poor. And that failure to harness technology in one way or another is at the heart of many of these high-risk problems.

So in order to effectively implement this and find out solutions, we went to the private sector to learn from leading organizations. And we published a guide called "Best Practices in Information Management," and we issued 11 different practices. And we have been working with the Congress to get these embodied in legislation.

And that is what the Paperwork Reduction Act does and the Clinger-Cohen Act. It requires and establishes for the first time chief information officers throughout the government. It focuses on building technology and information systems in modular procurements. It focuses on reengineering before you buy technology. It requires system architectures, or blueprints, to be put in place to guide system development efforts.

So there is a number of important reforms that have just been passed by the Congress that, if effectively implemented, can help solve many of these problems and bring the government into the modern age of technology.

Also, the IT areas—information technology—is important to solving the two new areas that we identified as governmentwide problems. Information security: Basically, we found that the Federal Government systems are vulnerable to unauthorized access and manipulation, and that great numbers of actions are needed in order to fix these problems, both from internal risk as well as external risk to the systems.

Also, the year 2000 problem, which basically is a problem created by a two-digit memory and needs to be changed so that when the year 2000 comes computers do not read that as the year 1900: Effectively, we have put out a guide to agencies about how to prepare themselves to be ready.

And if I could call your attention to the white chart here, basically, best practices tell you there need to be four phases that agencies need to go through to be ready. First, they have to be aware of the problem; they need to assess and go through an inventory of their systems, focus on some of their key vulnerabilities, go through the lines of code; then make the changes in the renovation stage; and then keep, basically, 1999 available for testing. So you basically have that last year that needs to be available for perfecting the changes.

HIGH-RISK AREAS

Ensuring All Revenues Are Collected and Accounted For

- IRS Receivables
- Filing Fraud
- IRS Financial Management
- Tax Systems Modernization
- Customs Service Financial Management
- Asset Forfeiture Programs

Controlling Fraud, Waste, Abuse, and Mismanagement in Benefit Programs

- Medicare
- Supplemental Security Income (new)

Focusing on Governmentwide Technology Issues

- Information Security (new)
- The Year 2000 Problem (new)

We are concerned that many agencies are not moving as fast as they need to in the assessment phase; thereby further condensing the time available to make the needed changes. And in many areas, the government's computer systems are not well documented, the Code is old, and there need to be a number of changes put in place. And agencies also need to have contingency plans. So this is a pressing problem that we are calling to the attention of the Congress and the agencies.

And the second major type of reform is financial management. In 1990, the Congress passed the Chief Financial Officers Act, which for the first time brought a requirement for Federal agencies to have financial audits. It is the same type of requirement that was put in place by the private sector many years ago, and of State and local governments.

Implementation of the CFO Act has been at the heart of some of the progress that the IRS and Customs have made in fixing some of their financial management problems. And also, right now the act has been extended to all executive branch agencies, effective with audits beginning in fiscal year 1996. So we think this Chief Financial Officers Act provides a set of best practices, proven practices, to fix some of the underlying financial management and control problems.

The third major reform is the Congress legislating the government Performance and Results Act in 1993. That act calls for the first time for agencies to produce strategic plans and have performance measures. The requirement for that act comes to fruition governmentwide this year. By September 1997, agencies are required to have strategic plans and performance measures.

I call that to your attention because agencies are required to consult with the Congress in preparing these plans, so that over the next few months this Subcommittee can play an important role in working with the agencies to shape those strategic plans and how we measure performance. And measuring performance is very, very important to assuring that we have an ability to track agencies' progress, in terms of whether making meaningful change or not.

That concludes my remarks. I think that we are working hard to try to help solve these problems. These management reforms that have been passed by the Congress—none of which were in place when we began the high-risk series 7 years ago—we think are important and, if collectively used, implemented, and encouraged by the Congress through oversight hearings, we think will go a long way to bringing some lasting improvements to these problems.

With that, I will turn it over, with your permission, Madam Chairman, to Lynda, to talk about the Internal Revenue Service.

[The prepared statement follows:]

Statement of Gene L. Dodaro, Assistant Comptroller General, Accounting and Information Management Division, U.S. General Accounting Office

Madame Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss major government programs and operations we have identified as high risk because of vulnerabilities to waste, fraud, abuse, and mismanagement. In 1990, we began a special effort to focus attention on such areas, and over the past several years we have made hundreds of recommendations to get at the heart of high-risk problems and help improve this situation. On February 12, 1997, we issued our latest series of high-risk reports.[1]

Overall, legislative and agency actions have resulted in progress toward fixing these high-risk areas and establishing a solid foundation to help ensure greater progress. However, because these areas involve long-standing problems which are difficult to fix, additional corrective measures are necessary to remove the high-risk designation.

Today, at the Subcommittee's request, we will focus on high-risk areas related to the Internal Revenue Service (IRS) and the Medicare and Supplemental Security In-

[1] The 25 areas that are the current focus of our high-risk initiative area listed in attachment I, and the reports in our 1997 high-risk series are listed in attachment II.

come (SSI) programs. While this statement provides a brief synopsis of these areas, more detailed statements on these three topics are also being issued today. In addition, this statement will discuss other high-risk areas that affect agencies under the Subcommittee's jurisdiction, including the Customs Service's financial management, information security weaknesses, and the possibility of serious computer disruptions in service to the public due to the Year 2000 Problem.

As the key message of this testimony, I would like to emphasize the importance of the Subcommittee using recent legislative management reforms to help oversee these agencies' actions to fully and effectively remedy their high-risk problems. These include

—the 1995 Paperwork Reduction Act and the 1996 Clinger-Cohen Act, which provide a basis for agencies to better manage investments in information technology;

—the expanded Chief Financial Officers (CFO) Act of 1990, which requires agencies to prepare financial statements that can pass the test of an independent audit and provide decisionmakers more reliable financial information; and

—the 1993 Government Performance and Results Act (GPRA), which requires agencies to measure performance and focus on results.

ENSURING ALL REVENUES ARE COLLECTED AND ACCOUNTED FOR

In 1995, IRS reported collecting $1.4 trillion from taxpayers, disbursing $122 billion in tax refunds, and managing an estimated accounts receivable inventory of $113 billion in delinquent taxes. The reliability of IRS' financial information is critical to effectively manage the collection of revenue to fund the government's operations.

Our audits of IRS' financial statements, however, have identified many significant weaknesses in IRS' accounting for revenue and accounts receivable, as well as for funds provided to carry out IRS' operations. IRS has improved payroll processing and accounting for administrative operations and is working on solutions to revenue and accounts receivable accounting problems. But much remains to be done, and effective management follow-through is paramount to achieving fully the goals of the CFO Act.

In addition, IRS is hampered in efficiently and effectively managing its huge inventory of accounts receivable due to inadequate management information. The root cause here is IRS' antiquated information systems and outdated business processes, which handle over a billion tax returns and related documents annually. IRS has undertaken many initiatives to deal with its accounts receivable problems, including correcting errors in its tax receivable masterfile and attempting to speed up aspects of the collection process. Efforts such as these appear to have had some impact on collections and the tax debt inventory, but many of the efforts are long-term in nature and demonstrable results may not be available for some time.

Further, while IRS' efforts to reduce filing fraud have resulted in some success—especially through more rigid screening in the electronic filing program—this continues to be a high-risk area. IRS' goal is to increase electronic filings, which would strengthen its fraud detection capabilities. But to effectively achieve its electronic filing goal, IRS must (1) identify those groups of taxpayers who offer the greatest opportunity for filing electronically and (2) develop strategies focused on alleviating impediments that have inhibited those groups from participating in the program.

In attempting to overhaul its timeworn, paper-intensive approach to tax return processing, IRS has spent or obligated over $3 billion on its tax systems modernization, which has encountered severe difficulties. Currently, funding for tax systems modernization has been curtailed, and IRS and the Department of the Treasury are taking several steps to address modernization problems and implement our recommendations. However, much more progress is needed to fully resolve serious underlying management and technical weaknesses.

Behind IRS, the Customs Service is the next highest revenue collector. The Customs Service has made considerable progress in correcting major management and organizational structure weaknesses we pointed to in our 1992 high-risk report. In 1995, we reported that Customs had taken several actions to address these problems, including revising its planning process, improving controls over identification and collection of revenues owed, aggressively pursuing delinquent receivables, and embarking on an agencywide reorganization plan. As a result, we narrowed the scope of our high-risk work at Customs to focus only on its financial management problems.

Since 1995, Customs has continued to take actions to address its financial management and internal control weaknesses. These include, for example, statistically sampling compliance of commercial importations through ports of entry to better focus enforcement efforts and to project and report duties, taxes, and fees lost due

to noncompliance. However, Customs still has not fully corrected significant problems in these areas. For example, audits of Customs' financial statements under the CFO Act disclose that Customs continues to lack adequate assurance that all revenue due is collected, has weaknesses in readily detecting duplicate and excessive drawback payments, and lacks integrated core financial systems. These problems diminish Customs' ability to reasonably ensure that (1) duties, taxes, and fees on imports are properly assessed and collected and refunds of such amounts are valid and (2) core financial systems provide reliable information for managing operations.

We have made numerous recommendations to Customs to address its financial management weaknesses and have assisted in developing corrective actions. It will be important for top management at Customs to provide continuing support to ensure that the planned financial management improvements are properly implemented.

CONTROLLING FRAUD, WASTE, ABUSE AND MISMANAGEMENT IN BENEFIT PROGRAMS

Medicare—the nation's second largest social program—is inherently vulnerable to and a perpetually attractive target for exploitation. The Congress and the President have been seeking to introduce changes to Medicare to help control program costs, which were $197 billion in fiscal year 1996. At the same time, they are concerned that the Medicare program loses significant amounts due to persistent fraudulent and wasteful claims and abusive billings, which could be from $6 billion to as much as $20 billion, based on 1996 outlays. The Congress passed the Health Insurance Portability and Accountability Act of 1996 to add funding for program safeguard efforts and make the penalties for Medicare fraud more severe. Effective implementation of this legislation and other agency actions are key to mitigating many of Medicare's vulnerabilities to fraud and abuse.

Also, the Health Care Financing Administration (HCFA), which runs the Medicare program, has begun to acquire a new claims processing system—the Medicare Transaction System (MTS)—to provide, among other things, better protection from fraud and abuse. In the past, we have reported on risks associated with this project, including (1) HCFA's plan to implement the system in a single stage rather than incrementally, (2) difficulty in defining requirements, (3) inadequate investment analysis, and (4) significant schedule problems. HCFA has responded to these concerns by changing its single-stage approach to one under which the system will be implemented incrementally and working to resolve other reported problems.

A newly designated high-risk area involves overpayments in the SSI program, which provided about $22 billion in federal benefits to recipients between January 1, 1996, and October 31, 1996. SSI overpayments have grown to over $1 billion per year, which is about 5 percent of total benefit payments. Also, criticisms have been raised regarding the Social Security Administration's (SSA) ability to effectively manage SSI workloads and internal control weaknesses that leave the program susceptible to fraud, waste, and abuse. For example, in August 1996, we reported that about 3,000 current and former prisoners in 13 county and local jail systems had been erroneously paid $5 million in SSI benefits, primarily because SSA lacked timely and complete information.

One root cause of SSI overpayments is SSA's difficulty in corroborating financial eligibility information that program beneficiaries self report and that affects their benefit levels. In addition, determining whether an impairment qualifies a claimant for disability benefits can often be difficult, especially in cases involving applicants with mental impairments and other hard-to-diagnose conditions.

ADDRESSING GOVERNMENTWIDE INFORMATION TECHNOLOGY ISSUES

In addition to the difficulties agencies have in managing large computer systems modernization efforts, our high-risk effort identified two governmentwide information technology issues that affect agencies under the Committee's purview: information security and the Year 2000 Problem.

Information Security

Information systems security weaknesses pose high risk of unauthorized access and disclosure of sensitive data. Many federal operations that rely on computer networks are attractive targets for individuals or organizations with malicious intentions. Examples of such operations include law enforcement, import entry processing, and various financial transactions.

Since June 1993, we have issued over 30 reports describing serious information security weaknesses at major federal agencies. For example, our financial audits at IRS and the Customs Service have identified poor computer controls. IRS cannot ensure that the confidentiality and accuracy of taxpayer data are protected and that

the data are not manipulated for purposes of individual gain. The Customs Service continues to have problems that diminish its ability to reasonably ensure that sensitive data maintained in automated systems are adequately protected from unauthorized access and modification.

In September 1996, we reported that during the previous 2 years, serious information security control weaknesses had been reported for 10 of the 15 largest federal agencies. We have made dozens of recommendations for improvement to individual agencies, and they have started acting on many of them.

In addition, we have recommended ways for the Office of Management and Budget (OMB) to enhance its ability to oversee and improve federal information security programs. We suggested steps that OMB can take to (1) effectively use opportunities to aid in overseeing and improving agency information security programs—such as annual financial audits and the newly created Chief Information Officers Council, and (2) increase the expertise of its staff in information security management issues.

The Year 2000 Problem

The Year 2000 Problem poses the high risk that computer systems throughout government will fail to run or malfunction because computer equipment and software were not designed to accommodate the change of date at the new millennium. For example, IRS' tax systems could be unable to process returns, which in turn could jeopardize the collection of revenue and the entire tax processing system. Or SSA's disability insurance process could experience major disruptions if the interface with various state systems failed, thereby causing delays and interruptions in disability payments to citizens.

We recently issued a guide, Year 2000 Computing Crisis: An Assessment Guide (GAO/AIMD–10.1.14, exposure draft), to provide agencies a framework and a checklist for assessing their readiness to achieve year 2000 compliance. It provides information on the scope of the challenge, and offers a structured approach for reviewing the adequacy of agency planning and management of the year 2000 program.

CONTINUING CONGRESSIONAL OVERSIGHT USING NEW MANAGEMENT TOOLS IS KEY

Continued congressional oversight, such as this hearing by the Subcommittee, will add essential impetus to make improvements and ensure more progress in addressing the high-risk areas just discussed and, thus, to achieve greater benefits. Effective and sustained follow-through by agency managers is necessary to resolve specific high-risk problems and implement broader management reforms, which the Congress has established to achieve better financial and information management and measure the results of program operations.

The Subcommittee can focus on agencies' progress in fixing specific high-risk problems and implementing this legislative framework through the following three efforts.

• Apply a framework of modern technology management, as required by the 1995 Paperwork Reduction Act and the Clinger-Cohen Act of 1996.

This framework is based on practices followed by leading public and private sector organizations that have successfully used technology to dramatically improve performance and meet strategic goals. These laws fundamentally revamp and modernize federal information management practices by emphasizing the involvement of senior executives in information management decisions, establishing senior-level Chief Information Officers, tightening controls over technology spending, redesigning inefficient work processes, and using performance measures to assess technology's contribution to achieving mission results. These management practices provide agencies—such as IRS for tax systems modernization—a proven, practical means of addressing the federal government's information problems, maximizing benefits from technology spending, and controlling the risks of systems development efforts.

• Improve financial reporting and make other financial management improvements, as called for by the expanded Chief Financial Officers Act.

The landmark CFO Act spelled out a long overdue and ambitious agenda to help resolve financial management problems. This act has prompted many improvements at IRS, the Customs Service, and other agencies to provide reliable financial information for managing government programs. Fully and effectively implementing the CFO Act is critical to achieving full accountability and providing relevant information on the government's true financial status.

In addition, improved reporting and internal controls, as called for by the CFO Act, can produce substantial savings in high-risk areas. For example, better data and controls can help reduce the billions of dollars now lost annually in the Medi-

care program due to fraudulent and abusive claims and help decrease the $1 billion in overpayments that the SSI program experiences each year.

• Use the Government Performance and Results Act to measure performance and focus on results, which can help to pinpoint opportunities for improved performance and increased accountability.

GPRA requires agencies to set goals, measure performance, and report on their accomplishments. Under GPRA, every major federal agency must now ask itself basic questions about performance to be measured and how performance information can be used to make improvements. For instance, performance measures would be useful for (1) reaching agreement with the Congress on and monitoring acceptable levels of errors in benefit programs (errors which may never be totally eliminated but can be much better controlled) and (2) assessing the results of tax enforcement initiatives, delinquent tax collection activities, and filing fraud reduction efforts.

Without additional attention to resolving problems in the high-risk areas that we have discussed today, the government will continue to miss important opportunities to ensure effective revenue collection operations, have well controlled and operated information systems, and save billions of dollars. We will continue to identify other ways for agencies to more effectively manage and control these and other high-risk areas and to make recommendations for improvements that can be implemented to overcome the root causes of these problems.

Madame Chairman, this concludes my statement. I will be happy to respond to any questions.

Attachment I

Areas Designated High Risk

PROVIDING FOR ACCOUNTABILITY AND COST-EFFECTIVE MANAGEMENT OF DEFENSE PROGRAMS

Financial management (1995)
Contract management (1992)
Inventory management (1990)
Weapon systems acquisition (1990)
Defense infrastructure (1997)

ENSURING ALL REVENUES ARE COLLECTED AND ACCOUNTED FOR

IRS financial management (1995)
IRS receivables (1990)
Filing fraud (1995)
Tax Systems Modernization (1995)
Customs Service financial management (1991)
Asset forfeiture programs (1990)

OBTAINING AN ADEQUATE RETURN ON MULTIBILLION DOLLAR INVESTMENTS IN INFORMATION TECHNOLOGY

Tax Systems Modernization (1995)
Air traffic control modernization (1995)
Defense's Corporate Information Management initiative (1995)
National Weather Service modernization (1995)
Information security (1997)
The Year 2000 Problem (1997)

CONTROLLING FRAUD, WASTE, AND ABUSE IN BENEFIT PROGRAMS

Medicare (1990)
Supplemental Security Income (1997)

MINIMIZING LOAN PROGRAM LOSSES

HUD (1994)
Farm loan programs (1990)
Student financial aid programs (1990)

IMPROVING MANAGEMENT OF FEDERAL CONTRACTS AT CIVILIAN AGENCIES

Department of Energy (1990)
NASA (1990)

Superfund (1990)
Also, planning for the 2000 Decennial Census was designated high risk in February 1997.

Attachment II

1997 High-Risk Series

An Overview (GAO/HR–97–1)
Quick Reference Guide (GAO/HR–97–2)
Defense Financial Management (GAO/HR–97–3)
Defense Contract Management (GAO/HR–97–4)
Defense Inventory Management (GAO/HR–97–5)
Defense Weapon Systems Acquisition (GAO/HR–97–6)
Defense Infrastructure (GAO/HR–97–7)
IRS Management (GAO/HR–97–8)
Information Management and Technology (GAO/HR–97–9)
Medicare (GAO/HR–97–10)
Student Financial Aid (GAO/HR–97–11)
Department of Housing and Urban Development (GAO/HR–97–12)
Department of Energy Contract Management (GAO/HR–97–13)
Superfund Program Management (GAO/HR–97–14)
The entire series of 14 high-risk reports is numbered GAO/HR–97–20SET.

Chairman JOHNSON. Thank you.
Ms. Willis.

STATEMENT OF LYNDA D. WILLIS, DIRECTOR, TAX POLICY AND ADMINISTRATION ISSUES, GENERAL GOVERNMENT DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. WILLIS. Good morning. It is good to be here again with you today, as we continue our efforts to improve the operations of the Internal Revenue Service.

A key factor in understanding IRS' ongoing difficulties in the high-risk areas is the realization that its major processes and systems were developed and implemented decades ago, and were not designed to address the critical needs and vulnerabilities that confront IRS in the nineties.

In addition, the problems that IRS faces in eliminating its high-risk vulnerabilities are compounded by their interdependencies. IRS' success in addressing the weaknesses in its program areas is clearly linked to its success in modernizing its systems. However, this understanding does not mitigate our concern over IRS' progress in developing a comprehensive business strategy or plan for modernizing its processes and systems.

For years we have chronicled IRS' struggle to manage its operations, and have made scores of recommendations to improve IRS' systems, processes, and procedures. In order to achieve its stated goals of reducing the volume of paper returns, improving customer service, and enhancing voluntary compliance with the tax system, IRS needs to ensure that its new and revised processes drive its systems development and implementation.

Solving problems in the high-risk areas is not an insurmountable task, but it requires sustained management commitment, accurate information systems, and reliable performance measures to track IRS' progress and to provide the data necessary to make sound management decisions.

There are four longstanding high-risk areas at IRS: Tax systems modernization, financial management, accounts receivable, and filing fraud. In addition, two of the new governmentwide high-risk areas also directly affect IRS operations: Information security, and the year 2000 problem or century date change.

Turning to each of these areas, I would like to briefly discuss the progress IRS has made and the measures IRS must take to solve them. For tax systems modernization, in July 1995 we reported that IRS did not have a comprehensive business strategy to effectively reduce paper tax return filings; had not yet fully developed and put in place the requisite management software development and technical infrastructure necessary to successfully implement its ambitious world class modernization; and lacked an overall systems architecture, or blueprint, to guide the modernization's development and evolution.

At that time, we made over a dozen recommendations to the Commissioner to address these weaknesses. In 1996, we reported that IRS had initiated many activities to improve its modernization efforts, but had not yet fully implemented any of our recommendations.

Since then, IRS has taken additional steps. For example, a new Chief Information Officer has been hired, as well as additional technical expertise. IRS also created an investment review board that has reevaluated and terminated several modernization development projects that were found not to be cost effective. IRS is also updating its systems development life cycle methodology, and is developing a systems architecture and project sequencing plan for the modernization.

While we recognize the IRS' actions, we remain concerned because much remains to be done to fully implement essential improvements and successfully modernize the IRS. It will take both management commitment and technical expertise for IRS to accomplish these tasks.

Our audits of IRS' financial statements have outlined the substantial improvements needed in IRS' accounting and reporting in order to comply fully with the requirements of the CFO Act. IRS has made progress in addressing these areas, and has been working to position itself to have more reliable financial statements for fiscal year 1997 and thereafter.

To accomplish this, especially in accounting for revenue and related accounts receivable, IRS will need to institute long-term solutions involving reprogramming software for its antiquated systems and developing new systems. Followthrough to complete corrective actions is essential if IRS is to solve the financial management problems it faces.

Turning to accounts receivable, IRS' ability to effectively address its accounts receivable problems is seriously hampered by outdated equipment and processes, incomplete information to better target its collection efforts, and the absence of a comprehensive strategy and detailed plan to address the systemic nature of the underlying problems. IRS' collection efforts have also been hampered by the age of the delinquent tax accounts.

In the last 2 years, IRS has undertaken several initiatives to overcome its deficiencies. Specifically, it has efforts underway to

correct errors in its master file records of tax receivables, develop profiles of delinquent taxpayers, and study the effectiveness of various collection techniques.

It has also streamlined its collection process, placed additional emphasis on contacting repeat delinquents, made its collection notices more readable, and targeted compliance-generated delinquencies for earlier intervention.

Despite these positive results, IRS needs to continue the development of the information databases and performance measures its managers need to determine which actions or improvements generate the desired changes in IRS programs and operations.

This is not a short-term commitment. It will be some time before the full results of the new initiatives are realized. IRS must take deliberate action to ensure that its problem-solving efforts are on the right track. It needs to implement a comprehensive strategy that involves all aspects of IRS operations and that sets priorities, accelerates the modernization of outdated equipment and processes, and establishes realistic goals, specific time tables, and a system to measure progress.

When we first identified filing fraud as a high-risk area in 1995, the amount of filing fraud being detected by IRS was on an upward spiral. Since then, IRS has introduced new controls and expanded existing controls in an attempt to reduce its exposure. These controls are directed toward either preventing the filing of fraudulent returns or identifying questionable returns after they have been filed.

IRS' efforts have produced some positive results. For example, IRS efforts to validate Social Security numbers on paper returns produced over $800 million in reduced refunds or additional taxes.

IRS was less successful in identifying fraudulent returns, identifying over 65 percent fewer fraudulent returns in 1996 than during a comparable period in 1995. IRS believes this decrease is attributable to a 31-percent reduction in its fraud detection staff and the resulting underutilization of its electronic fraud detection system which enhances the identification of fraudulent returns. However, IRS does not have the information it needs to verify that the decline was the result of staff reductions, or by a general decline in the incidence of fraud.

Given the decrease in fraud detection staff, it is critically important for IRS to optimize the electronic controls that are intended to prevent the filing of fraudulent returns, and to maximize the effectiveness of available staff. Modernization is the key to achieving these objectives.

Turning now to two new governmentwide high-risk areas, IRS is vulnerable to problems in both. Related to information security, as the result of our recent work at IRS, we believe that the vulnerabilities of IRS computer systems may affect the confidentiality and accuracy of taxpayer data and may allow unauthorized access, modification, or destruction of taxpayer information. IRS does not have a proactive information security group that systematically reviews the adequacy and consistency of security over IRS computer operations.

The year 2000 problem at IRS is such that it could create a disruption of functions and services that could jeopardize almost all

of IRS' tax processing systems. It could effectively halt the processing of tax returns and related return information, the maintenance of taxpayer accounts, the assessment and collection of taxes, the recording of obligations and expenditures, and the disbursement of refunds.

To avoid the crippling effects of a multitude of computer systems simultaneously producing inaccurate and unreliable information, IRS must assign management and oversight responsibility within its senior executive corps to find the potential impact of such systems failure and develop appropriate renovation strategies and contingency plans for its critical systems.

Madam Chairman, Members of the Subcommittee, in summary, for years IRS has struggled to collect the Nation's tax revenues using outdated processes and technology. To address its high-risk problem areas, IRS needs an implementation strategy for modernizing its systems and processes that includes developing cost-benefit analyses and reasonable estimates of timeframes and resources required. Above all, IRS management needs to sustain an agencywide commitment to solving these problems.

[The prepared statement follows:]

Statement of Lynda D. Willis, Director, Tax Policy and Administration Issues, General Government Division, U.S. General Accounting Office

Madam Chairman and Members of the Subcommittee:

We are pleased to be here today to assist the Subcommittee in its review of the Internal Revenue Service's (IRS) efforts to improve the efficiency and effectiveness of its program areas that we have identified as high risk because of their vulnerability to waste, fraud, abuse, and mismanagement. A key factor in understanding IRS' ongoing difficulties in the high-risk areas is the realization that its major processes and systems were developed and implemented decades ago and were not designed to address the critical needs and vulnerabilities that confront IRS in the 1990s. In addition, the problems IRS faces in attempting to eliminate its high-risk vulnerabilities are compounded by the interdependency of the high-risk areas. For example, IRS' success in addressing the weaknesses in its program areas is clearly linked to its success in modernizing its information systems. However, this understanding of the difficulties IRS faces does not mitigate our concern over IRS' progress in developing a comprehensive strategy or detailed business plan to modernize its outdated processes and systems. Without successfully modernizing its processes and systems, IRS cannot hope to resolve the problems in its high-risk areas.

OVERVIEW

In February 1997, we issued our third series of reports on the status of high-risk areas across the government.[1] One report in the series discussed the four long-standing high-risk areas at IRS: (1) tax systems modernization—IRS' development of the business and management strategies, software acquisition and development capabilities, and technical infrastructure and systems architecture needed to modernize its systems and processes; (2) financial management—IRS' efforts to properly account for its tax revenues, obligations, and disbursements; (3) accounts receivable—IRS' initiatives to better understand the composition of its tax debt inventory and to devise effective collection strategies and reliable programs to prevent future delinquencies; and (4) filing fraud—IRS' efforts to gather sufficient information to determine the effectiveness of its attempts to deter the filing of fraudulent returns.[2]

Our 1997 high-risk report series also designated five new high-risk areas, two of which have government-wide implications and directly affect IRS' operations.[3] One area is information security—IRS' initiatives to better protect the confidentiality and accuracy of taxpayer data from unauthorized access and manipulation. The other area is the year 2000 problem—IRS' plans to protect itself from the oper-

[1] GAO/HR-97–20SET.
[2] GAO/HR-97–8.
[3] GAO/HR-97–9.

ational and financial impacts that could affect tax processing and revenue collection systems if its computer systems cannot accommodate the change of date to the year 2000.

Today, we will briefly discuss the problems IRS faces in these six high-risk areas, the progress IRS has made since our last series of high-risk reports in 1995, and the measures IRS must take to resolve the problems in its high-risk areas. This testimony is based on our prior reports and recent information obtained from IRS.

IRS' HIGH-RISK AREAS

For years we have chronicled IRS' struggle to modernize and manage its operations, especially in the high-risk areas, and have made scores of recommendations to improve IRS' systems, processes, and procedures. It is clear that in order to achieve its stated goals of reducing the volume of paper tax returns, providing better customer service, and improving compliance with the nation's tax laws, IRS must successfully modernize its systems and operations. To accomplish this modernization, however, IRS needs to develop comprehensive business strategies to ensure that its new and revised processes drive systems development and acquisition. Solving the problems in the high-risk areas is not an insurmountable task, but it requires sustained management commitment, accurate information systems, and reliable performance measures to track IRS' progress and provide the data necessary to make informed management decisions.

Tax Systems Modernization

Over the last decade, IRS has been attempting to overhaul its timeworn, paper-intensive approach to tax return processing. At stake is the over $3 billion that IRS has spent or obligated on this modernization since 1986, as well as any additional funds that IRS plans to spend on the modernization.

In July 1995, we reported that IRS (1) did not have a comprehensive business strategy to cost-effectively reduce paper tax return filings; (2) had not yet fully developed and put in place the requisite management, software development, and technical infrastructure necessary to successfully implement its ambitious, world-class modernization; and (3) lacked an overall systems architecture, or blueprint, to guide the modernization's development and evolution.[4] At that time, we made over a dozen recommendations to the IRS Commissioner to address these weaknesses.

Pursuant to subsequent congressional direction, we assessed IRS' actions to correct its management and technical weaknesses. We reported in June and September 1996 that IRS had initiated many activities to improve its modernization efforts but had not yet fully implemented any of our recommendations.[5] We also suggested to Congress that it consider limiting modernization funding exclusively to cost-effective efforts that (1) support ongoing operations and maintenance; (2) correct IRS' pervasive management and technical weaknesses; (3) are small, represent low technical risk, and can be delivered quickly; and (4) involve deploying already developed and fully tested systems that have proven business value and are not premature given the lack of a completed architecture.

IRS has taken steps to address our recommendations and respond to congressional direction. For example, IRS hired a new Chief Information Officer. It also created an investment review board to select, control, and evaluate its information technology investments. Thus far, the board has reevaluated and terminated several major modernization development projects that were not found to be cost-effective. In addition, IRS provided a report to Congress in November 1996 that set forth IRS' strategic plan and its schedule for shifting modernization development and deployment to contractors.

IRS is also finalizing a comprehensive strategy to maximize electronic filing that is currently scheduled for completion in May 1997. It is also updating its system development life cycle methodology and is working across various IRS organizations to define disciplined processes for software requirements management, quality assurance, configuration management, and project planning and tracking. Additionally, IRS is developing a systems architecture and project sequencing plan for the modernization and intends to provide this to Congress by May 15, 1997.

---

[4] Tax Systems Modernization: Management and Technical Weaknesses Must Be Corrected If Modernization Is to Succeed (GAO/AIMD–95–156, July 26, 1995).

[5] Tax Systems Modernization: Actions Underway But IRS Has Not Yet Corrected Management and Technical Weaknesses (GAO/AIMD–96–106, June 7, 1996) and *Tax Systems Modernization: Actions Underway But Management and Technical Weaknesses Not Yet Corrected* (GAO/T–AIMD–95–165, Sept. 10, 1996).

While we recognize IRS' actions, we remain concerned because much remains to be done to fully implement essential improvements. Increasing the use of contractors, for example, will not automatically increase the likelihood of successful modernization because IRS does not have the technical capability needed to manage all of its current contractors. To be successful, IRS must also continue to make a concerted, sustained effort to fully implement our recommendations and respond effectively to the requirements outlined by Congress. It will take both management commitment and technical discipline for IRS to accomplish these tasks.

Financial Management

Our audits of IRS' financial statements have outlined the substantial improvements needed in IRS' accounting and reporting in order to comply fully with the requirements of the Chief Financial Officers Act of 1990 (CFO Act). The audits for fiscal years 1992 through 1995 have described IRS' difficulties in (1) properly accounting for its tax revenues, in total and by reported type of tax; (2) reliably determining the amount of accounts receivable owed for unpaid taxes; (3) regularly reconciling its Fund Balance With Treasury accounts; and (4) either routinely providing support for receipt of the goods and services it purchases or, where supported, accurately recording the purchased item in the proper period.

IRS has made progress in addressing problems in these areas and has developed an action plan, with specific timetables and deliverables, to address the issues our financial statement audits have identified. In the administrative accounting area, for example, IRS reported that it has identified substantially all of the reconciling items for its Fund Balance With Treasury accounts, except for certain amounts IRS has deemed not to be cost-beneficial to research further. It also has successfully transferred its payroll processing to the Department of Agriculture's National Finance Center and has begun designing both a short-term and a long-term strategy to fix the problems that contribute to its nonpayroll expenses being unsupported or reported in the wrong period.

In the revenue accounting area, IRS' problems are especially affected and complicated by automated data processing systems that were implemented many years ago and thus not designed to support the new financial reporting requirements imposed by the CFO Act. Therefore, IRS has designed an interim solution to capture the detailed support for revenue and accounts receivable until longer-term solutions can be identified and implemented. Some of the longer-term actions include (1) implementing software, hardware, and procedural changes needed to create reliable subsidiary accounts receivable and revenue records that are fully integrated with the general ledger; and (2) implementing software changes that allow the detailed taxes reported to be maintained separately from the results of compliance efforts that would not be valid financial reporting transactions in the masterfile, other related revenue accounting feeder systems, and the general ledger.

Over the past 4 years, we have made numerous recommendations to improve IRS' financial management systems and reporting, and IRS has been working to position itself to have more reliable financial statements for fiscal year 1997 and thereafter. To accomplish this, especially in accounting for revenue and the related accounts receivables, IRS will need to institute long-term solutions involving reprogramming software for IRS' antiquated systems and developing new systems as required.

Follow-through to complete necessary corrective measures is essential if IRS is to ensure that its corrective actions are carried out and effectively solve its financial management problems. Solving these problems is fundamental to providing reliable financial information and ensuring taxpayers that the government can properly account for their federal tax dollars. The accuracy of IRS' financial statements is vital to both IRS and Congress for (1) ensuring adequate accountability for IRS programs; (2) assessing the impact of tax policies; and (3) measuring IRS' performance and cost effectiveness in carrying out its numerous tax enforcement, customer service, and collection activities.

Accounts Receivable

IRS routinely collects over a trillion dollars annually in taxes, but many taxpayers are unable or unwilling to pay their taxes when due. As a result, IRS estimates that its accounts receivable amounts to tens of billions of dollars. Unfortunately, IRS' ability to effectively address its accounts receivable problems is seriously hampered by its outdated equipment and processes, incomplete information needed to better target collection efforts, and the absence of a comprehensive strategy and detailed plan to address the systemic nature of the underlying problems.

IRS' collection efforts have also been hampered by the age of the delinquent tax accounts. Because of the outdated equipment and processes used to match tax returns and related information documents, it can take IRS several years to identify

potential delinquencies and then initiate collection actions. In addition, according to IRS, the 10-year statutory collection period generally precludes it from writing off uncollectible receivables until that period has expired. As a result, the receivables inventory includes many relatively old accounts that will never be collected because the taxpayers are deceased or the companies defunct.

This is not to say, however, that IRS has not been trying to overcome its deficiencies. In the last 2 years, IRS has undertaken initiatives to correct errors in its masterfile records of tax receivables, develop profiles of delinquent taxpayers, and study the effectiveness of various collection techniques. It has also streamlined its collection process, placed additional emphasis on contacting repeat delinquents, made its collection notices more readable, and targeted compliance-generated delinquencies for earlier intervention.

IRS reported that, as a result of taking these actions, its collection employees took in more money than they classified as "currently not collectible" and that the amount of money collected immediately following the revision of its collection notices increased by almost 25 percent over a comparable period in 1995. In addition, IRS reported collecting more in delinquent taxes in fiscal year 1996 than it ever has, almost $30 billion.

Despite these positive results, IRS needs to continue the development of information databases and performance measures to afford its managers the data needed to determine which actions or improvements generate the desired changes in IRS' programs and operations. And, this should not be looked upon as a short-term commitment. It will still take a number of years to identify the root causes of delinquencies and to develop, test, and implement courses of action to deal with the causes. Furthermore, once the analyses and planning are completed, it will still be some time before full results of the new initiatives are realized.

Therefore, IRS must take deliberate action to ensure that its problem-solving efforts are on the right track. Specifically, it needs to implement a comprehensive strategy that involves all aspects of IRS' operations and that sets priorities; accelerates the modernization of outdated equipment and processes; and establishes realistic goals, specific timetables, and a system to measure progress.

Filing Fraud

When we first identified filing fraud as a high-risk area in February 1995, the amount of filing fraud being detected by IRS was on an upward spiral. Since then, IRS has introduced new controls and expanded existing controls in an attempt to reduce its exposure to filing fraud. Those controls are directed toward either (1) preventing the filing of fraudulent returns or (2) identifying questionable returns after they have been filed.

To deter the filing of fraudulent returns, IRS (1) expanded the number of up-front filters in the electronic filing system designed to screen electronic submissions for selected problems in order to prevent returns with those problems from being filed electronically and (2) strengthened the process for checking the suitability of persons applying to participate in the electronic filing program as return preparers or transmitters by requiring fingerprint and credit checks.

To better identify fraudulent returns once they have been filed, IRS placed an increased emphasis in 1995 on validating social security numbers (SSN) on filed paper returns and delayed any related refunds to allow time to do those validations and to check for possible fraud. IRS also revised the computerized formulas it used to score all tax returns as to their fraud potential and upgraded the research capabilities of its fraud detection staff.

IRS' efforts produced some positive results. For example, the number of SSN problems identified by the electronic filing filters quadrupled between 1994 and 1995, and about 350 persons who applied to participate in the electronic filing program for 1995 were rejected because they failed the new fingerprint and credit checks. IRS' efforts to validate SSNs on paper returns produced over $800 million in reduced refunds or additional taxes. Unfortunately, IRS identified many more SSN problems than it was able to deal with and released about 2 million refunds without resolving the problems.

IRS was less successful in identifying fraudulent returns, identifying over 65 percent fewer fraudulent returns in 1996 than during a comparable period in 1995. IRS believes this decrease is attributable to a 31-percent reduction in its fraud detection staff and the resulting underutilization of its Electronic Fraud Detection System, which enhances the identification of fraudulent returns and lessens the probability of improperly deleting accurate refunds. However, IRS does not have the information it needs to verify that the decline was the result of staff reductions or to determine the extent to which the downward trend may have been affected by changes

in the program's operating and reporting procedures or by a general decline in the incidence of fraud.

Given the decrease in fraud detection staff, it is critically important for IRS to (1) optimize the electronic controls that are intended to prevent the filing of fraudulent returns and (2) maximize the effectiveness of available staff. Modernization is the key to achieving these objectives, and electronic filing is the cornerstone of that modernization. One solution, then, is to increase the percentage of returns filed electronically. To achieve this goal, IRS must first identify those groups of taxpayers who offer the greatest opportunity to reduce IRS' paper-processing workload and operating costs if they were to file electronically. IRS must then develop strategies that focus its resources on eliminating or lessening impediments that inhibit those groups from participating in the program.

Information Security

Malicious attacks on computer systems are an increasing threat to our national welfare. The federal government now relies heavily on interconnected systems to control critical functions which, if compromised, place billions of dollars worth of assets at risk of loss and vast amounts of sensitive data at risk of unauthorized disclosure. Increasing reliance on networked systems and electronic records has elevated our concerns about the possibility of serious disruption to critical federal operations.

As a result of our recent work at IRS, we believe that the vulnerabilities of IRS' computer systems may affect the confidentiality and accuracy of taxpayer data and may allow unauthorized access, modification, or destruction of taxpayer information. The overriding problem at IRS is that information security issues are addressed on a reactive basis. IRS does not have a proactive, independent information security group that systematically reviews the adequacy and consistency of security over IRS' computer operations. In addition, computer security management has not completed a formal risk assessment of its systems to determine system sensitivity and vulnerability. As a result, IRS cannot effectively prevent or detect unauthorized browsing of taxpayer information and cannot ensure that taxpayer data is not being improperly manipulated for personal gain.

IRS needs to address its information security weaknesses on a continuing basis. More specifically, IRS needs to impress upon its senior managers the need to conduct regular systematic security reviews and risk assessments of IRS' computer systems and operations. The weaknesses identified by these reviews and assessments then need to be corrected expeditiously by personnel who have the technical expertise to effectively implement, manage, and monitor the necessary security controls and measures.

The Year 2000 Problem

For the past several decades, computer systems have used two digits to represent the year, such as "97" for 1997, in order to conserve electronic data storage and reduce operating costs. In this format, however, the year 2000 is indistinguishable from the year 1900 because both are represented as "00." As a result, if not modified, computer systems and applications that use dates or perform date- or time-sensitive calculations may generate incorrect results beyond 1999.

For IRS, such a disruption of functions and services could jeopardize all of its tax processing systems and administration. It could effectively halt the processing of tax return and return-related information, the maintenance of taxpayer account information, the assessment and collection of taxes, the recording of obligations and expenditures, and the disbursement of refunds. At the very least, IRS' core business functions and mission-critical processes are at risk of failure, as is numerous other administrative and management processes.

To avoid the crippling effects of a multitude of computer systems simultaneously producing inaccurate and unreliable information, IRS must assign management and oversight responsibility within its senior executive corps, define the potential impact of such a systems failure, and develop appropriate renovation strategies and contingency plans for its critical systems. Modifying IRS' critical computer systems is a massive undertaking whose success or failure will, in large part, be determined by the quality of IRS' executive leadership and program management.

SUMMARY OUTLOOK

For years, IRS has struggled to collect the nation's tax revenue using outdated processes and technology. The result has often been inefficient and ineffective programs and operations that are vulnerable to waste, fraud, abuse, and mismanagement. Of particular concern to us have been IRS' efforts to modernize its tax systems, manage its administrative and revenue accounting systems, identify and col-

lect taxes owed the government, detect and prevent the filing of fraudulent tax returns, protect the confidentiality of taxpayer information, and prevent the future disruption of tax services due to computer malfunctions.

These areas of concern share common characteristics that IRS must address in the very near future. At a minimum, IRS needs an implementation strategy that includes both performing cost-benefit analyses and developing reasonable estimates of the extent, time frames, and resources required to correct its high-risk vulnerabilities. IRS also needs to (1) better define, prioritize, implement, and manage new information systems; (2) ensure that its administrative and revenue accounting systems fully comply with government accounting standards; (3) design and implement both administrative and electronic controls to protect taxpayer data from unauthorized access; and (4) develop performance measures that will allow its managers, Congress, and us to track its progress. And, above all, IRS management needs to sustain an agencywide commitment to solving the agency's high-risk problems.

Madam Chairman, this concludes my prepared statement. We will be glad to answer any questions that you or the Members of the Subcommittee may have.

Chairman JOHNSON. Thank you, Ms. Willis.

Ms. Ross.

STATEMENT OF JANE L. ROSS, DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. ROSS. Good morning. I am pleased to be here to discuss the Supplemental Security Income Program and our decision to designate it as one of our high-risk areas. As you know, the SSI Program provides means tested income support payments to eligible aged, blind, and disabled persons.

Before I discuss SSI's vulnerabilities, let me give you a little background on the program. SSI was enacted in 1974. It is almost entirely financed by Federal taxes, and it is run by the Social Security Administration. SSI now has about 6.6 million recipients who receive benefits totaling over $27 billion a year, virtually all of which are Federal dollars.

While you may not hear as much about SSI as other welfare programs such as AFDC or food stamps, the dollars spent on SSI are larger than those spent on AFDC, and are about the same as those spent on food stamps. In other words, SSI is a major Federal welfare program.

There are several longstanding problems in SSI that caused us to designate the program as high risk. These problems involve the methods SSA uses to verify recipients' initial and continuing eligibility for SSI benefits, and the Agency's efforts to get SSI recipients into the work force.

These deficiencies have placed the program at considerable risk and contributed to significant annual increases in overpayments. During 1996, SSA had $2.3 billion in SSI overpayments that was owed to them, including almost $900 million in newly detected overpayments during the year. The Agency was successful in recovering only 15 percent of the amount they were owed.

This morning I want to give you a better understanding of why we consider SSI a high-risk program, by discussing just one area of vulnerability: The way in which SSA determines whether individuals are financially eligible for the program.

Individuals cannot have income greater than $484 a month, nor have resources worth more than $2,000, in order to qualify. Applicants have to tell all about their income sources, as well as information on assets, marital status, living arrangements, and any changes in those things, including whether you become incarcerated or become a resident in a nursing home.

To verify that the information provided by recipients is accurate, SSA generally relies on matching data from other Federal and State agencies, such as VA benefits data and State unemployment data. SSA needs accurate and timely information because it is much easier to prevent overpayments than to recover them later.

However, we have found that the data from computer matches is often quite old and incomplete. For example, computer matches in the employment and earned income area are from 6 to 21 months old, so that overpayments accrue for at least that long before collection actions can begin.

Another weakness in this process is that SSA does not conduct some matches which actually might detect overpayments. For example, SSA has not matched its data with AFDC records to detect SSI recipients who may be receiving benefits from that source.

Our work in the last few years suggests that recipients do not always report required information when they should, and may not report it at all. For example, last year we reported that about 3,000 current and former prisoners in 13 of the Nation's largest county and local jails had been erroneously paid millions of dollars in SSI benefits, mainly because SSA lacked timely and complete information on their incarceration.

Also, some recipients may be making false reports. SSA staff have indicated that reports of changes in living arrangements are frequently subject to abuse. One common scenario involves recipients who become eligible for SSI benefits and shortly thereafter report to SSA that they have separated from their spouse and are living in separate residences. SSA field staff suspects that these reported changes occur as recipients become aware that separate living arrangements will substantially increase their monthly benefits.

To obtain more timely and accurate recipient data, SSA is currently testing the use of online access to State databases to supplement the information it already receives. Online access provides direct connections between SSA's computers and the computers maintained by certain State agencies. Data can be obtained by SSA staff as soon as it is requested and used to verify the amount of AFDC or other benefit income.

We believe that nationwide use of online access to State computerized income data could prevent or more quickly detect about $130 million in overpayments each year. Although some States can currently provide online access to their data inexpensively and easily, SSA has moved too slowly in this area.

In addition to State data, online access to other Federal agencies' data may also greatly help SSA, but SSA has moved slowly in this area, as well. Overall, SSA is not sufficiently alert to current problems in verifying data related to financial eligibility, nor sufficiently active in pursuing new techniques to mitigate these problems.

Let me conclude at this point. The problems we have identified in the SSI Program are long standing and have contributed to billions of tax dollars being overpaid to recipients. They have also served to compromise the integrity of the program and reinforce public perceptions that the SSI Program pays benefits to too many people for too long.

Although many of the changes recently enacted by the Congress or implemented by SSA may result in improvements, the underlying problems still exist. In light of welfare reform, the importance of having tight controls on SSI is even greater. As time limits and work requirements begin to be felt, it is likely that both individuals and States will look for opportunities to move people onto the SSI roles.

Our work has shown that SSI's vulnerability is due both to problems in program design and inadequate SSA management attention to the program. Revising SSA's approach to managing the program will require sustained attention and direction at the highest levels of the Agency.

One challenge for the new SSA Commissioner will be to focus greater Agency attention on management of SSI and the future viability and integrity of the program. This completes my statement.

[The prepared statement follows:]

Statement of Jane L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Madame Chairman and Members of the Subcommittee:

I am pleased to be here to discuss the Social Security Administration's (SSA) Supplemental Security Income (SSI) program and our decision to designate the program one of our high-risk areas. As you know, the SSI program provides means-tested income support payments to eligible aged, blind, or disabled people. Since the program's inception in 1974, the number of individuals receiving SSI cash benefits has grown significantly. About 6.6 million recipients now receive roughly $22 billion in federal benefits. In the past several years, a major reason for growth in the SSI rolls has been an increasing number of younger recipients with mental impairments who have limited work histories. Rapid growth in the number of children receiving SSI benefits has further contributed to changes in the program's character. The increased number and diversity of SSI recipients has spurred criticism that the SSI program is increasingly susceptible to fraud, waste, and abuse. Through our work, we have also demonstrated that the SSI program has been adversely affected by internal control weaknesses, complex policies, and insufficient management attention. (A list of related GAO products dealing with SSI program vulnerabilities appears at the end of this statement).

Today, I would like to discuss several long-standing problems in SSI that have caused us to designate the program as high risk. These problems involve the methods SSA uses to verify recipients' initial and continuing eligibility for SSI benefits and the agency's efforts to get SSI recipients into the workforce. These deficiencies have placed the program at considerable risk and contributed to significant annual increases in overpayments to SSI recipients. Overpayments include payments to people ineligible for the program, as well as to those receiving higher benefit payments than their income and assets warrant. During 1996, SSA had $2.3 billion in overpayments that was owed to the agency, including $895 million in newly detected overpayments during the year. In that year, the agency was successful in recovering only $357 million of the total outstanding debt.

To briefly summarize our findings, the SSI program has had significant problems in determining initial and continuing financial eligibility because of the agency's reliance on individuals' own reports of their income and resources and failure to thoroughly check this information. Moreover, the judgmental nature of SSA's disability determination process and SSA's past failure to adequately review SSI recipients to determine whether they remain disabled have also exposed the program to fraud, waste, and abuse. Finally, SSA is at risk of paying some SSI recipients benefits for too long because it has not adequately addressed their special vocational rehabilitation needs nor developed an agencywide strategy for helping recipients who can

enter the workforce. The Congress has recently made several changes that address program eligibility issues and increase the frequency of SSA's continuing eligibility reviews. SSA has also begun addressing its program vulnerabilities and has made the prevention of fraud and abuse a part of its plan for rebuilding public confidence in the agency. However, our concerns about underlying SSI program vulnerabilities and the level of management attention devoted to these vulnerabilities continue. As part of our high-risk work, we are continuing to evaluate the underlying causes of long-standing SSI problems and the actions necessary to address them.

BACKGROUND

SSI provides cash benefits to low-income aged, blind, or disabled people. Currently, the aged SSI population is roughly 1.4 million and the blind and disabled population more than 5.2 million. Those who are applying for benefits on the basis of age must be age 65 or older and be financially eligible for benefits; those who are applying for disability benefits must qualify on the basis of two criteria: financial and disability eligibility. To qualify for benefits financially, individuals may not have income greater than the current maximum monthly SSI benefit level of $484 ($727 for a couple) or have resources worth more than $2,000 ($3,000 for a couple). To be qualified as disabled, applicants must be unable to engage in any substantial gainful activity because of an impairment expected to result in death or last at least 12 months.

The process SSA uses to determine an applicant's financial eligibility for SSI benefits involves an initial determination when someone first applies and periodic reviews to determine whether the recipient remains eligible. SSI recipients are required to report significant events that may affect their financial eligibility for benefits, including changes in income, resources, marital status, or living arrangements, such as incarceration or residence in a nursing home. To verify that the information provided by a recipient is accurate, SSA generally relies on matching data from other federal and state agencies, including the Internal Revenue Service form 1099 information, Department of Veterans Affairs benefits data, and state-maintained earnings and unemployment benefits data. When SSA staff find discrepancies between income and assets claimed by a recipient and the data from other agencies, they send notices to SSA field offices to investigate further.

To determine a person's qualifications for SSI as a disabled person, SSA must determine the individual's capacity to work as well as his or her financial eligibility. To determine whether an applicant's impairment qualifies him or her for SSI benefits, SSA uses state Disability Determination Services (DDS) to make the initial assessment. Once a recipient begins receiving benefits, SSA is required to periodically conduct Continuing Disability Reviews (CDR) to determine whether a recipient's condition remains disabling.

Regarding returning recipients to work, the Social Security Act states that to the maximum extent possible, individuals applying for disability benefits should be rehabilitated into productive activity. To this end, SSA is required to refer SSI recipients to state vocational rehabilitation agencies for services intended to prepare them for returning to work. The act also provides various work incentives to safeguard cash and medical benefits while a recipient tries to return to work.

SSA PAYS INADEQUATE ATTENTION TO VERIFYING RECIPIENTS' FINANCIAL ELIGIBILITY

To correctly determine an individual's initial and continuing financial eligibility, SSA needs accurate and timely information because it is much easier to prevent overpayments than to recover them. SSA tries to get this information directly from applicants and recipients but also supplements this data through the use of computer matches with other federal and state agencies. To do this, SSA compares federal and state data with information claimed by SSI applicants. In many instances, these matches allow SSA to detect information that SSI recipients fail to report; in other cases, they provide more accurate information. However, our prior reviews have found that data from computer matches are often quite old and sometimes incomplete. For example, computer matches for earned income rely on data that are from 6 to 21 months old, allowing overpayments to accrue for this entire period before collection actions can begin. This puts SSI at risk because it collects only about 15 percent of outstanding overpayments. Another weakness in this process is that SSA does not conduct some matches that could help to detect additional overpayments. For example, SSA has not matched data from Aid to Families With Dependent Children (AFDC) to detect SSI recipients who may be receiving benefits from this program.

Our work in the last few years suggests that recipients do not always report required information when they should and may not report it at all. For example, last year we reported that about 3,000 current and former prisoners in 13 county and local jails had been erroneously paid $5 million in SSI benefits, mainly because SSA lacked timely and complete information on their incarceration. Recipients or their representative payees did not report the incarceration to SSA as required, and SSA had not arranged for localities to report such information. SSA told us that it has begun a program to identify SSI recipients in jails who should no longer be receiving benefits.

Our ongoing SSI work is identifying similar program problems and weaknesses as those noted in prior reports. For example, SSA staff have indicated that recipients' reporting of changes in living arrangements is frequently subject to abuse. One common scenario involves recipients who become eligible for SSI benefits and shortly thereafter report to SSA that they have separated from their spouse and are living in separate residences. SSA field staff suspect that these reported changes in living arrangements take place because recipients become aware that separate living arrangements will substantially increase their monthly benefits. Another ongoing study of SSI recipients admitted to nursing homes has found that despite SSA procedures and recent legislation to encourage reporting such living arrangement changes, thousands of SSI recipients in nursing homes continue to receive full benefits, resulting in millions of dollars in overpayments each year. This happens because recipients and nursing homes do not report changes in living arrangements and because computer matches with participating states to detect nursing home admissions are not done in a timely manner and are often incomplete. Consequently, these admissions and the resulting overpayments are likely to go undetected for long time periods.

In a final area related to financial eligibility, we recently reported that between 1990 and 1994, approximately 3,500 SSI recipients transferred ownership of resources, such as cash, houses, land, and other items valued at an estimated $74 million to qualify for SSI benefits. This figure represents only transfers of resources that recipients actually told SSA about. Although these transfers are legal, using them to qualify for SSI benefits raises serious questions about SSA's ability to protect taxpayer dollars from waste and abuse and may undermine the public's confidence in the program. SSA has acknowledged and supports the need to work with the Congress to develop legislation to address this problem.

To obtain more timely and accurate recipient data, SSA is currently testing the use of online access to state databases to supplement the information it receives. Online access provides direct connections between SSA's computers and the databases maintained by certain state agencies. Data can be obtained immediately by SSA staff as soon as requested and used for a variety of purposes, including verifying the amount of AFDC or other benefit income a client reports. After reviewing this SSA initiative, we concluded that nationwide use of online access to state computerized data could prevent or more quickly detect about $130 million in overpayments due to unreported or underreported income in one 12-month period. Online access could save program dollars by controlling overpayments and reducing the administrative expense of trying to recover them. In responding to our review, SSA noted that it was exploring options for expanding online access and was examining the cost-effectiveness of doing so. Although some states can currently provide online access to their data inexpensively and easily, SSA has moved slowly in this area. In addition to state data, online access to other federal agencies' data may help SSA save program dollars. SSA has also moved slowly in this area, however.

PROGRAM VULNERABILITIES ARE ASSOCIATED WITH DETERMINING DISABILITY ELIGIBILITY

In addition to financial eligibility, for those who apply for disability benefits, SSA must also determine their disability eligibility or their capacity to work. SSA's lengthy and complicated disability decision-making process results in untimely and inconsistent decisions. Adjudicators at all levels of this process have to make decisions about recipients' work capacity on the basis of complex and often judgmental disability criteria. Determining disability eligibility became increasingly difficult in the early 1990s as younger individuals with mental impairments began to apply for benefits in greater numbers. Generally, mental impairments are difficult to evaluate, and the rates of award are higher for these impairments than for physical impairments.

SSA's processes and procedures for determining disability have placed the SSI program at particular risk for fraud, waste, and abuse. For example, in 1995, we reported that SSA's ability to ensure reasonable consistency in administering the

program for children with behavioral and learning disorders had been limited by the subjectivity of certain disability criteria. To address these problems, recent welfare reform legislation included provisions to tighten the eligibility rules for childhood disability and remove children from the rolls who have qualified for SSI on the basis of less restrictive criteria. It is too early, however, to tell what impact the new legislation will ultimately have on SSI benefit payments and SSA's ability to apply consistent disability policies to this population.

In addition, we reported in 1995 that middlemen were facilitating fraudulent SSI claims by providing translation services to non-English-speaking individuals who were applying for SSI. These middlemen were coaching SSI claimants on appearing mentally disabled, using dishonest health care providers to submit false medical evidence to those determining eligibility for benefits, and providing false medical information on claimants' medical and family history. In one state alone, a middleman arrested for fraud had helped at least 240 people obtain $7 million in SSI benefits. SSI's vulnerability to fraudulent applications involving middlemen was the result of the lack of a comprehensive strategy for keeping ineligible applicants off the SSI rolls, according to our review. SSA told us that half of all SSI field office recent hires are bilingual, a step that it believes will reduce the involvement of fraudulent middlemen.

In light of the difficulty of determining disability and SSI's demonstrated vulnerability to fraud and manipulation, periodic reviews are essential to ensure that recipients are disabled. Our work has shown, however, that SSA has not placed adequate emphasis on CDRs of SSI cases. In 1996, we reported that many recipients received benefits for years without having any contact with SSA about their disability. We also noted that SSA performed relatively few SSI CDRs until the Congress mandated in 1994 that it conduct such reviews. Furthermore, SSA's processes for identifying and reviewing cases for continuing eligibility did not adequately target recipients with the greatest likelihood for medical improvement.

Currently, SSA is implementing new review requirements in the welfare reform law. In addition, SSA had about 2½ million required CDRs due or overdue in the Disability Insurance (DI) program and 118,000 SSI CDRs due or overdue as of 1996. Despite the importance of CDRs for ensuring SSI program integrity, competing workloads from implementing welfare reform legislation will challenge SSA in completing the required number of SSI CDRs.

SSA Has not Emphasized Return to Work and Vocational Rehabilitation

As mentioned previously, the Social Security Act states that as many people as possible who are applying for disability benefits should be rehabilitated into productive activity. We have found, however, that SSA places little priority on helping recipients move off the SSI rolls by obtaining employment. Yet, if only a small proportion of recipients were to leave the SSI rolls by returning to work, the savings in lifetime cash benefits would be significant.

Technological and societal changes in the last decade have raised the possibility of more SSI recipients returning to work. For example, technological advances, such as standing wheelchairs and synthetic voice systems, have made it easier for people with disabilities to enter the workplace. Legislative changes, such as the Americans With Disabilities Act, and social changes, such as an increased awareness of the economic contributions of individuals with disabilities, have also enhanced the likelihood of these individuals finding jobs. During the past decade, the proportion of middle-aged SSI recipients has steadily increased. Specifically, the number of SSI recipients between the ages of 30 and 49 has increased from 36 percent in 1986 to about 46 percent in 1995 to about 1.6 million people. Thus, many SSI recipients have many productive years in which to contribute to the workforce.

Despite these factors, SSA has missed opportunities to promote work among disabled SSI recipients. In 1972, the Congress created the plan for achieving self-support (PASS) to help low-income individuals with disabilities return to work. The program allows SSI recipients to receive higher monthly benefits by excluding from their SSI eligibility and benefit calculations any income or resources used to pursue a work goal. SSA pays about $30 million in additional cash benefits annually to PASS program participants. Despite these cash outlays, almost none of the participants leave the rolls by returning to work.

SSA has poorly implemented and managed the PASS program. In particular, SSA has developed neither a standardized application containing essential information on the applicant's disability, education, and skills nor ways to measure program effectiveness. We have recommended that SSA act on several fronts to control waste and abuse and evaluate the effect of PASS on recipients' returning to work. In gen-

eral, SSA has agreed with our recommendations and taken some steps to more consistently administer the PASS program.

In the past several months, however, several efforts have begun to place a greater emphasis on returning disabled people to work. The administration is seeking statutory authority to create a voucher system that recipients could voluntarily use to get rehabilitation and employment services from public or private providers and is also seeking legislation to extend medical coverage for recipients who return to work. The Congress has also put forth several proposals in these areas.

CONCLUSION

The problems we have identified in the SSI program are long-standing and have contributed to billions of tax dollars being overpaid to recipients. They have also served to compromise the integrity of the program and reinforce public perceptions that the SSI program pays benefits to too many people for too long. Although many of the changes recently enacted by the Congress or implemented by SSA may result in improvements, the underlying problems still exist.

Our work has shown that SSI's vulnerability is due both to problems in program design and inadequate SSA management attention to the program. Revising SSA's approach to managing the program will require sustained attention and direction at the highest levels of the agency as well as actively seeking the cooperation of the Congress in improving the program's operations and eligibility rules. One challenge for the new SSA Commissioner will be to focus greater agency attention on management of SSI and the future viability and integrity of this program.

This concludes my prepared statement. I will be happy to respond to any questions you or other members of the Subcommittee may have.

For more information on this testimony, please call Jane Ross on (202) 512–7230 or Roland Miller, Assistant Director, on (202) 512–7246.

RELATED GAO PRODUCTS

Social Security Disability: Improvements Needed to Continuing Disability Review Process (GAO/HEHS–97–1, Oct. 16, 1996).

Supplemental Security Income: SSA Efforts Fall Short in Correcting Erroneous Payments to Prisoners (GAO/HEHS–96–152, Aug. 30, 1996).

Supplemental Security Income: Administrative and Program Savings Possible by Directly Accessing State Data (GAO/HEHS–96–163, Aug. 29, 1996).

SSA Disability: Return-to-Work Strategies From Other Systems May Improve Federal Programs (GAO/HEHS–96–133, July 11, 1996).

Social Security: Disability Programs Lag in Promoting Return to Work (GAO/T–HEHS–96–147, June 5, 1996).

SSA Disability: Program Redesign Necessary to Encourage Return to Work (GAO/HEHS–96–62, Apr. 24, 1996).

Supplemental Security Income: Some Recipients Transfer Valuable Resources to Qualify for Benefits (GAO/HEHS–96–79, Apr. 30, 1996).

PASS Program: SSA Work Incentive for Disabled Beneficiaries Poorly Managed (GAO/HEHS–96–51, Feb. 28, 1996).

Supplemental Security Income: Disability Program Vulnerable to Applicant Fraud When Middlemen Are Used (GAO/HEHS–95–116, Aug. 31, 1995).

Social Security: New Functional Assessments for Children Raise Eligibility Questions (GAO/HEHS–95–66, Mar. 10, 1995).

Chairman JOHNSON. Thank you very much.

Ms. Aronovitz.

STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Ms. ARONOVITZ. Thank you. Good morning, Chairman Johnson, and Members of the Subcommittee. We are pleased to be here today to discuss efforts to fight fraud and abuse in the Medicare Program. As you know, while changes to Medicare are being sought

to help control program costs, the Congress is concerned that billions of dollars are lost to fraudulent and wasteful claims.

Today I would like to address Medicare's fee-for-service and managed care programs, their problems, recent initiatives to address them, and several remaining concerns.

First, in Medicare's fee-for-service program, HCFA and its claims processing contractors have struggled to carry out critical claims review and provider audit activities with a declining budget. Claims have climbed 70 percent over the last 7-year period, while the amount contractors could spend on claims review shrank, in today's dollars, from 74 cents per claim to 38 cents per claim.

The effect of inadequate funding on contractors' reviews of claims has been felt. Take home health, for instance. In 1986 and 1987, contractors reviewed 62 percent of home health claims processed. By 1989, however, HCFA lowered the contractors' claims review target to 3.2 percent.

In 1996, the Health Insurance Portability and Accountability Act, also known as HIPAA, infused badly needed funds into Medicare's antifraud and abuse activities. In fiscal year 1997, the act gradually boosts the contractors' budget for program safeguard activities each year until the year 2003, after which it remains constant.

These additional funds, however, essentially stabilize per-claim safeguard activities and expenditures at about 1996's level, and will still be only half of what was spent in 1989, in real dollars.

Another important fraud fighting effort is the 2-year multiagency project called Operation Restore Trust, which I could discuss in greater detail, if you would like, later. Notwithstanding funding issues, HCFA could improve oversight aspects of its antifraud and abuse activities.

In addition to better coordinating contractors' reviews of claims before the checks are cut, HCFA needs to be vigilant over its information management efforts. This includes its acquisition of MTS, Medicare's big new claims processing system. But even before MTS is completed, HCFA must manage several types of system conversions, one involving the consolidation of several part A and part B systems currently operating into a single system for each part; and another involving the mechanics of making digit changes in computer systems to accommodate the year 2000.

I would now like to talk a bit about Medicare's managed care and its own set of risks for taxpayers and beneficiaries. As we recently testified before the Ways and Means Subcommittee on Health, a methodological flaw in HCFA's approach to paying HMOs has produced excess payments for some plans. We are proposing a modification to HCFA's method that would improve the accuracy of the basic county rate on which the HMO payment is based. That could save hundreds of millions of dollars annually in Medicare expenditures.

A second problem is that HCFA has been lax in enforcing HMO compliance with program standards. And finally, HCFA currently does not provide beneficiaries any of the comparative information on benefits and premiums that FEHBP and many employers routinely provide their retirees. HCFA also collects a wealth of information on HMO performance that it does not package for public consumption.

HCFA acknowledges these problems, and is working to address them. The HIPAA legislation gives HCFA more flexible sanction authority, such as suspending an HMO's right to enroll Medicare beneficiaries until deficiencies are corrected.

Also, HCFA is developing several consumer information efforts that are a small first step in helping beneficiaries compare features of competing HMOs in their areas. We have some suggestions to improve those efforts, also.

In summary, many of Medicare's vulnerabilities are inherent in its size and mission, making it a perpetually attractive target for exploitation. HCFA needs to make judicious use of HIPAA funding for program safeguards, mitigate MTS acquisition risks, and oversee information management transitions.

Also, HCFA must work to ensure that payments to HMOs better reflect the cost of beneficiaries' care, that the Agency's expanded authority to enforce HMO compliance with Federal standards is used, and that beneficiaries receive information about HMOs sufficient to make informed choices. To adequately protect taxpayers' dollars, as well as beneficiaries, HCFA needs to meet these important challenges promptly.

Thank you. This concludes my statement, and I believe we will all be very happy to answer any questions you may have.

[The prepared statement follows:]

Statement of Leslie G. Aronovitz, Associate Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss efforts to fight fraud and abuse in the Medicare program, one of the largest entitlement programs in the federal budget. In fiscal year 1996, federal spending for Medicare was $197 billion. Program expenditures have been growing at about 9 percent per year. Moreover, the trust fund that pays for hospital and other institutional services is projected to be depleted within 5 years. As you know, while changes to Medicare are being sought to help control program costs, the Congress is concerned that billions of dollars of these costs are lost to fraudulent and wasteful claims.

Today, I would like to address Medicare's fee-for-service and managed care programs. More specifically, with regard to these two programs, I'd like to highlight the problems bearing on protecting taxpayer and beneficiary interests in Medicare, initiatives recently taken by the Congress and federal agencies addressing these problems, and several remaining concerns.

In summary, it is not surprising that because of the program's size, complexity, and rapid growth, Medicare is a charter member of our high risk series. (See the list of related GAO products at the end of this statement.) In this year's report on Medicare, we are pleased to note that both the Congress and the Health Care Financing Administration (HCFA), the Department of Health and Human Services' (HHS) agency responsible for running Medicare, have made important legislative and administrative changes addressing chronic payment safeguard problems that we and others have identified. However, because of the significant amount of money at stake, we believe that the government will need to exercise constant vigilance and effective management to keep the program protected from financial exploitation.

BACKGROUND

In 1996, Medicare's fee-for-service program covered almost 90 percent, or 33 million, of Medicare's beneficiaries. Physicians, hospitals, and other providers submit claims to Medicare to receive reimbursement. HCFA administers Medicare's fee-for-service program largely through an administrative structure of claims processing contractors. In 1965, when the Medicare program was enacted, the law called for insurance companies—like Blue Cross and Blue Shield, Travelers, and Aetna—to process and pay claims because of their expertise in performing these functions. As Medicare contractors, these companies use federal funds to pay health care provid-

ers and beneficiaries and are reimbursed for their administrative expenses incurred in performing the work. Over the years, HCFA has consolidated some of Medicare's operations, and the number of contractors has fallen from a peak of about 130 to about 70 in 1996. Generally, intermediaries are the contractors that handle part A claims submitted by "institutional providers" (hospitals, skilled nursing facilities, hospices, and home health agencies); carriers are those handling part B claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

HCFA's efforts to guard against inappropriate payments have been largely contractor-managed operations, leaving the fiscal intermediaries and carriers broad discretion over how to protect Medicare program dollars. As a result, there are significant variations in contractors' implementation of Medicare's payment safeguard policies.

Medicare's managed care program covers a growing number of beneficiaries—nearly 5 million in 1996—who have chosen to enroll in a health maintenance organization (HMO) to receive their medical care rather than purchasing services from individual providers. The managed care program, which is funded from both the part A and part B trust funds, consists mostly of risk contract HMOs and enrolled about 4 million Medicare beneficiaries in 1996.[1] The HMOs are paid a monthly amount, fixed in advance, by Medicare for each beneficiary enrolled. In this sense, the HMO has a "risk" contract because regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing health care within a fixed budget. HMOs profit if their cost of providing services is lower than the predetermined payment but lose if their cost is higher than the payment.

Recent Funding, Other Initiatives Revitalize Waning Efforts to Review Claims, Deter Abuse

Over the last 7 years, HCFA and its claims processing contractors have struggled to carry out critical claims review and provider audit activities with a budget that, on a per-claim basis, was seriously declining. For example, between 1989 and 1996, the number of Medicare claims climbed 70 percent to 822 million, while during that same period, claims review resources grew less than 11 percent. Adjusting for inflation and claims growth, the amount contractors could spend on review shrank from 74 cents to 38 cents per claim.

Implications of Reduced Funding for Payment Safeguards

Consider the effect of inadequate funding on reviewing home health claims. After legislation in 1985 more than doubled claims review funding, contractors did medical necessity reviews for 62 percent of the home health claims processed in 1986 and 1987. By 1989, however, contractors' claims review target had been lowered to 3.2 percent. One HCFA official noted that home health agencies are aware that their Medicare intermediary reviews only a small number of claims and, therefore, they can take chances billing for noncovered services.

The plunge in the number of cost report audits has also weakened Medicare's efforts to avoid paying excessive costs. Providers subject to these audits are those paid under Medicare's cost-based reimbursement systems—such as hospital outpatient departments, skilled nursing facilities, and home health agencies. These providers are reimbursed on the basis of the actual costs of providing services, rather than on charges. Each year, cost-based providers submit reports that detail their operating costs throughout the preceding year and specify the share related to the provision of Medicare services. Using this information, the intermediaries determine how much Medicare should reimburse the provider institutions, some of which have received interim Medicare payments throughout the year based on estimates of expected costs. Without an audit of the provider's cost report, however, the intermediary can only reconcile the figures provided and cannot determine the appropriateness of the costs reported. In practice, only a fraction of providers is subject to audits. Between 1991 and 1996, the chances, on average, that an institutional provider would be audited fell from about 1 in 6 to about 1 in 13.

The Impact of Recent Legislation and Other Initiatives

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the cycle of declining funding for anti-fraud-and-abuse activities has been broken. For fiscal year 1997, the act boosts the contractors' budget for program

[1] Other Medicare HMOs include cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to chhose health services from their HO network or outside providers. Health care prepayment plans may cover onlyl part B services. Together, both types of plans enroll fewer than 2 percent of the Medicare population.

safeguard activities to 10 percent higher than it was in 1996; by 2003, the level will be 80 percent higher than in 1996, after which it remains constant. These additional amounts, however, essentially stabilize per-claim safeguard expenditures at about 1996's level. For example, we project that payment safeguard spending for 2003 will be just over one-half the level of 1989 spending after adjusting for inflation.

In addition to funding, the act has several other provisions to improve vigilance over Medicare benefit dollars, including specifying the flexibility to use contractors other than those processing claims to perform utilization review, provider audit, and other safeguard activities; establishing a program run jointly by the Department of Justice and HHS to coordinate federal, state, and local law enforcement efforts against fraud in Medicare and other health care payers; establishing a national health care fraud data collection program; and enhancing penalties and establishing health care fraud as a separate criminal offense.

Another important fraud-fighting effort is the 2-year, multiagency project called Operation Restore Trust. Participating agencies include the HHS Inspector General, HCFA, and the Administration on Aging, as well as the Department of Justice and various state and local agencies. The project targets Medicare abuse and misuse in the areas of home health, nursing homes, and medical equipment and supplies. In its first year, Operation Restore Trust reported recovering $42.3 million in inappropriate payments: $38.6 million were returned to the Medicare trust fund and $3.7 million to the Treasury as a result of these efforts. It also resulted in 46 convictions, imposed 42 fines, and excluded 119 fraudulent providers from program participation. In addition, many of the targeted home health agencies were decertified. Operation Restore Trust is scheduled to be closed out as a demonstration project in May 1997. This effort, as well as HCFA's progress in adopting fraud and abuse detection software and its development of a national provider tracking system, is discussed further in our high risk report.

Management Problems Also Affect Medicare Payments and Operations

Notwithstanding funding increases, several problems independent of adequate funding and related to HCFA's oversight of Medicare have implications for curbing unnecessary spending and conducting program operations effectively. One chronic problem is that HCFA has not coordinated contractors' payment safeguard activities. For example, as was anticipated when the program was set up, part B carriers establish their own medical policies and screens, which are the criteria used to identify claims that may not be eligible for payment. Certain policies and the screens used to enforce them have been highly effective in helping some Medicare carriers avoid making unnecessary or inappropriate payments. However, the potential savings from having these policies and screens used by all carriers have been lost, as HCFA has not adequately coordinated their use among carriers. For example, for just six of Medicare's top 200 most costly services in 1994, the use of certain carriers' medical policy screens by all of Medicare's carriers could have saved in the millions to hundreds of millions of dollars annually. However, HCFA's leadership has been absent in this area, resulting in the loss of opportunity to avoid significant Medicare expenditures.

In addition, several technical and management problems have hampered HCFA's acquisition of the Medicare Transaction System (MTS), a major claims processing system that aims at consolidating the nine different claims processing systems Medicare currently uses. First, HCFA had not completely defined its requirements 2 years after awarding a systems development contract. Second, HCFA's MTS development schedule has had significant overlap among the various system-development phases, increasing the risk that incompatibilities and delays will occur. Finally, HCFA has conducted the MTS project without adequate information about the system's costs and benefits.

Before MTS is completed, HCFA must oversee several essential information management transitions in the Medicare claims processing environment. One involves the shifting of claims processing workloads from contractors who leave the program to other remaining contractors. Similar workload shifts in the past have produced serious disruptions in processing claims promptly and accurately, delays in paying physicians, and the mishandling of some payment controls. A second issue involves HCFA's plan to consolidate Medicare's three part A and six part B systems into a single system for each part. This plan will require several major software conversions. A third issue involves the "millennium" problem—revising computerized systems to accommodate the year-digit change to 2000. HCFA does not yet have plans for monitoring contractors' progress in making their systems "millennium compliant."

MEDICARE MANAGED CARE INCURS SEPARATE RISKS

Risk contract HMOs, Medicare's principal managed care option, bear their own set of risks for taxpayers and beneficiaries. These plans currently enroll about 10 percent of Medicare's population and have shown rapid enrollment growth in recent years. Because HMOs have helped private sector payers contain health care costs and limit the excess utilization encouraged by fee-for-service reimbursement, these HMOs have cost-control appeal for Medicare, while offering potential advantages to beneficiaries.

However, as we recently testified, a methodological flaw in HCFA's approach to paying HMOs has produced excess payments for some plans. Moreover, because higher HMO enrollment produces higher excess payments, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending unless the method of setting HMO rates is revised.

A second problem, of particular concern to beneficiaries, is that HCFA has been lax in enforcing HMO compliance with program standards, while not keeping beneficiaries adequately informed of the benefits, costs, and performance of competing HMOs. In 1995, we reported that, despite efforts to improve its HMO monitoring, HCFA conducted only paper reviews of HMOs' quality assurance plans, examining only the description rather than the implementation of HMOs' quality assurance processes. Moreover, the agency was reluctant to take action against noncompliant HMOs, even when there was a history of abusive sales practices, delays in processing beneficiaries' appeals of HMO decisions to deny coverage, or patterns of poor quality care.

HCFA also misses the opportunity to supplement its HMO regulatory efforts by not keeping the Medicare beneficiary population well-informed about competing HMOs. As we reported in 1996, HCFA has a wealth of data, collected for program administration and contract oversight purposes, that it does not package or disseminate for consumer use. For example, HCFA does not provide beneficiaries with any of the comparative consumer guides that the federal government and other employer-based health insurance programs routinely distribute to their employees and retirees. Instead, HCFA collects information only for its internal use—records of each HMO's premium requirements and benefit offerings, enrollment and disenrollment data (monthly reports specifying for each HMO the number of beneficiaries that joined and left that month), records of enrollees' complaints, and results of certification visits to HMOs. By not publishing disenrollment rates or other comparative performance measures, HCFA misses an opportunity to show beneficiaries which plans have a good record and hinders HMOs' efforts to benchmark their own performance.

Initiatives Intended to Address Risk Contract Program Problems

HCFA acknowledges the problems we identified in Medicare's risk contract program. To tackle the difficulties in setting HMO payment rates, HCFA has been conducting several demonstration projects that examine ways to modify or replace the current method of determining HMO payment rates. In addition, HIPAA gives HCFA more flexible sanction authority, such as suspending an HMO's right to enroll Medicare beneficiaries until deficiencies are corrected, while providing HMOs the statutory right to develop and implement a corrective action plan before HCFA imposes a sanction.

Finally, HCFA is developing several consumer information efforts, including plans to make HMO comparison charts available on the Internet. Providing the information in an electronic format rather than in print, however, may make it less accessible to the very individuals who would find it useful. The information, according to HCFA, will have to be "downloaded and customized for local consumption." HCFA expects the primary users of this information to be beneficiary advocates and Medicare insurance counselors. HCFA is also planning a survey to obtain beneficiaries' perceptions of their managed care plans and does not expect preliminary results before the end of 1997. In another key initiative, HCFA is helping to develop a new version of the Health Plan Employer Data and Information Set (HEDIS 3.0) that will incorporate measures relevant to the elderly population. The measures will enable comparisons to be made among plans of the enrollees' use of such prevention and screening services as flu shots, mammography, and eye exams for diabetics. As of January 1997, Medicare HMOs are required, from the time they renew their contract, to report on HEDIS 3.0 clinical effectiveness measures. HCFA intends to summarize the results and include them in comparability charts currently being developed.

CONCLUSION

Many of Medicare's vulnerabilities are inherent in its size and mission, making it a perpetually attractive target for exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance and increasingly sophisticated ways to protect against gaming the system. Judicious changes in Medicare's day-to-day operations involving HCFA's improved oversight and leadership, its appropriate application of new anti-fraud-and-abuse funds, and the mitigation of MTS acquisition risks are necessary ingredients to reduce substantial future losses. Moreover, as Medicare's managed care enrollment grows, HCFA must work to ensure that payments to HMOs better reflect the cost of beneficiaries' care, that beneficiaries receive information about HMOs sufficient to make informed choices, and that the agency's expanded authority to enforce HMO compliance with federal standards is used. To adequately safeguard the Medicare program, HCFA needs to meet these important challenges promptly.

This concludes my statement. I am happy to take your questions.

For more information on this testimony, please call Donald C. Snyder, Assistant Director, on (202) 512–7204. Other major contributors to this statement included Thomas Dowdal and Hannah F. Fein.

RELATED GAO PRODUCTS

High Risk Series Reports on Medicare

Medicare (GAO/HR–97–10)
Medicare Claims (GAO/HR–95–8)
Medicare Claims (GAO/HR–93–6)

Medicare Fee-For-Service

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS–96–16, Mar. 27, 1996).
Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS–96–49, Jan. 30, 1996).
Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success (GAO/T–AIMD–96–12, Nov. 16, 1995).
Medicare: Allegations Against ABC Home Health Care (GAO/OSI–95–17, July 19, 1995).
Medicare: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD–95–135, May 5, 1995).
Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD–94–79, Jan. 25, 1994).

Medicare Managed Care

Medicare HMOs: HCFA could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates (GAO/T–HEHS–97–78, Feb. 25, 1997).
Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS–97–23, Oct. 22, 1996).

Chairman JOHNSON. I thank the panel for your very interesting testimony. And there are lots of questions that each of you have raised. So we will take one round of questions and then probably come back.

Let me ask a kind of general question first that sounds simplistic, but does concern me. Since December 1992, GAO has been tracking 20 high-risk areas. This series adds five more. Should we be concerned about the list growing, and particularly about our inability to get agencies off the list? Does this mean that government is performing less effectively, or does it simply reflect a more aggressive policy on the part of GAO?

Mr. DODARO. I think the answer to that question is a little bit different for each of the areas that we have been tracking. But I think overall, to answer your question, I would be more concerned than I am had there not been some progress made in the past several years.

I think, as I pointed out in my opening statement, the Congress has really put in place some real critical management reforms. The question is, can those reforms be translated into concrete improvements and day-to-day management practices of the agencies? And I think that's a very important question. And the answer to that will go a long way to determining whether or not we are improving the effectiveness.

There is no question, however, right now that at the Federal level we are needlessly losing billions of dollars and missing huge opportunities to improve services to the public by not correcting these high-risk areas. And until we do, we cannot rest and be assured that we are going to have effective operations.

Adding some of the additional areas is our way of signaling in neon lights to the Congress that we need to pay attention to some of these problems coming up. Some of them are unique, such as the year 2000 problem. We also had concerns about the upcoming decennial census, which was another area that we added among the five.

Chairman JOHNSON. Of your 11 recommendations, how many did the new legislation of the last session address?

Mr. DODARO. The new legislation of the last session—I would have to get you the specifics on that, but I know in the Medicare area it did. There was the Agriculture Improvement Act that that addressed, and the Farmers Home, which is another area that we have. There were some efforts made in the SSI area which Jane mentioned. So I would say of these 11, there are probably at least one-third of them that there was specific legislation for that particular program.

Now, with all of these areas, the broad-based management reforms are important. I think it is important to point out, too, that the CFO Act, for example, requiring financial statements and independent audits does not become governmentwide implementation until this year. Even though the act was passed in 1990, it had a phased production schedule, which it unfolded in some pilot projects. IRS and Customs were two of the pilots, which was one of the reasons they have had financial statements and audits more than many other parts of the Federal Government.

So I think there have been some specific legislative initiatives in these areas. All of these areas are impacted by these broad management reforms, however. The information technology reforms that I talked about were the first time in over a decade that the Congress has modernized the government's information management practices. And we all know what has transpired in that arena over the last 10 years.

Those reforms largely became effective in August 1996. So this first year is a real critical year for agencies to begin implementing those acts. And our experience has been with management reforms historically that unless the Congress shows a lot of oversight and follows up with the agencies, they will be slow to implement some of these reforms. And we cannot afford to wait any longer.

Chairman JOHNSON. Well, that does very much concern me. I am pleased about the legislation. That certainly is a dramatic step forward. And I think the last Congress was far more reform-focused

than it has been given credit for. But it is critical that these be implemented.

A lot of the things that you talk about in the IRS—the lack of a comprehensive implementation strategy and detailed business plan for modernization—you have been saying for over 5 years, ever since the modernization of its technology project was undertaken.

Do you consider the failure to have moved more aggressively to address that kind of base problem the result of lack of leadership, or incompetence, or low bidder rules? I mean, how do you explain the fact that recommendations of that substance, which now of course are key, and we have seen now billions of dollars lost because the recommendations were not taken earlier—why does this keep happening? Is it bureaucratic incompetence, lack of leadership? Is it low bidder rules? What are we up against?

Mr. DODARO. I think in the tax system modernization effort—and I am going to ask Dr. Rona Stillman, who is our Chief Scientist for Computers and Telecommunications. She has been in charge of our work at IRS and also the air traffic control system in FAA. I will just make a few comments on why I think it is important, and I am sure Rona will elaborate.

Number one, it has not always received enough top attention by agency executives. And we do not have a well-defined business reason for pursuing the technology. So there is no link between exactly what we are doing in implementing hardware and software changes, and how that is going to accomplish the goal.

At IRS, for example, how the strategy would actually produce electronic filing was unclear to us. In fact, their strategy called for only having about 40 million returns electronically filed in a few years out. And it did not seem to make sense to us that you would spend that amount of money and only have that percent of those returns as a percentage of 220 million returns filed a year.

Second, agencies have not followed good software development processes. We find agencies that are not developing the software themselves. Oftentimes, we find ad hoc and chaotic software development; also, in the disciplined areas of developing requirements. Even if you are going to contract out in a number of cases, agencies are not following the disciplined practices in order to do that.

And it has been a problem in the private sector, as well, but they have managed the risk better and cut projects' funding earlier in the phases. And that is what we have made recommendations to IRS, in order to do that, as well. So business strategies, disciplined processes—all of these areas are pretty much addressed by the new technology reforms, but they need to be implemented.

Rona.

Ms. STILLMAN. Gene has answered the question thoroughly, I think. But just to sum up, IRS has lacked the technical discipline in areas of systems design and systems acquisition. The Agency does not have disciplined processes in place, and management has not been committed to instituting this discipline.

Part of the reason for this is that until very recently there has been no direct linkage between IRS' budgets and the results that they achieve, either in systems or in other expenditures, but in particular in systems. Their budgets for the next year have not re-

flected how effective they have been in accruing benefits from previous IT investments.

Until they are held responsible consistently for producing results, it is unclear how optimistic we can be that they will expeditiously institute change.

Mr. DODARO. I think, as it relates specifically to the IRS, I have been encouraged recently by the fact that, first of all, they have agreed with all of the recommendations that we have made to them over time. Second, we have begun to curtail bad investments in the system. They have actually stopped some of the projects which we had recommended and hoped they had done earlier. But they are finally coming around there.

They have also embarked upon developing a new electronic filing business strategy, which I think has to be something that the Congress and others agree to. And this relates to the performance measurements and strategic plans that are being developed under the government Performance and Results Act, as well.

We all need to agree on where we want to go and how we want to have the returns filed and what our goals are and are they realistic. So I think IRS has finally gotten the message in many of these areas and is beginning to take action. Unfortunately, some of the areas, particularly those that require instituting disciplined software development techniques, take many years to make improvements. And that is why we have recommended that the funding be given to IRS commensurate with their technical ability to develop projects; and until they can develop the ability to take on high-risk development projects, whether they are doing it themselves or through contractors, that the funding be controlled until they can prove that they can bring these things online in a repeated fashion—which is what we are after, is repeatability.

Chairman JOHNSON. In other words, that they have a disciplined process for developing either the system, themselves, or guidance to contractors, and that it be related to their strategic business goals.

Mr. DODARO. Right. That is clear, Madam Chairman. I mean, I think until the Congress understands exactly what we are going to get out of the investment that we are putting in there, in terms of improved service delivery to the public—and that was a problem, I think, with TSM.

Chairman JOHNSON. Right.

Mr. DODARO. The articulation of exactly what it was going to achieve was never clear. And in that case, I think that that begins to wave a yellow, if not red, flag to pay attention to those types of projects.

Chairman JOHNSON. But I do think the advisory board is already paying off. The elimination of the cyberfile development system, in which we put $17 million for no effect, clearly was the result of effective oversight by the review board.

Let me just ask one other question, and then turn it over to my colleagues. And later on I would like to come back to specific questions to the rest of you. But one of the general problems with the IRS is that they have this enormous amount of money that we call uncollectible.

It has always concerned me that what is described by us publicly as uncollectible—that is, by the government, or actually, accounts receivable—a lot of it is uncollectible. I think it is a mistake not to take whatever actions are necessary to assure that when you use the words "collectible" the public is getting accurate information.

Do you think that the 10-year statutory collection period prevents the IRS from writing off uncollectible receivables for that period, and therefore is part of the problem in misleading the public about the real nature of how much tax revenue we truly are failing to collect; as opposed to how much tax revenue we did not collect because part of it becomes uncollectible?

Mr. DODARO. Lynda, do you want to take that?

Ms. WILLIS. Madam Chairman, I do not think the issue is so much with the 10-year statutory period. I think the problem is being able to differentiate within the accounts receivable inventory how much of that is because of the extension of the statute, how much we know about which of the accounts are collectible or are not collectible.

This 10-year statute does generally require that IRS continue to carry these accounts on the books, and some of those accounts are collected over that period of time through refund offset or other means.

What we need is better understanding of the makeup of the inventory of accounts receivable, so that when we come to the Congress we can report, of the money that is in the accounts receivable inventory, how much of it are financial receivables; how much of it relates to compliance actions that have been taken by IRS, essentially place markers for what could be receivables but may not be if the taxpayer gets back to the IRS with additional information, and how much of the money within the financial receivables we believe is collectible.

All of those are very important pieces of information, in terms of us understanding how much of the money that is out there we can reasonably expect to collect in any period of time. But I do not think the 10-year period, while it is a constraint in terms of the total amount that is on the books, is an insurmountable problem, in terms of identifying how much money we actually can collect.

Chairman JOHNSON. Well, I am concerned about the big difference between the total number, which is $216 billion, and the financial receivables that are estimated to be $113 billion. And where we have that disparity, we may want to develop an approach that involves two different accounts: One of financial receivables, where we expect really to get the tax payments made; and some other category, where we expect, because of bankruptcy and death, that we will not.

Now, maybe at least where the entity has died, the person has died, we might be able to deal with those differently. But I think it is important not to leave out there the impression that we simply fail to collect $216 billion. That is just an enormous amount of money. And we need to be more realistic.

Mr. DODARO. Right.

Chairman JOHNSON. And if you could provide us with suggestions about how we might reform this portion of the law to more

honestly reflect the true status of the receivables, I would appreciate it.

Mr. DODARO. Well, I think, Madam Chairman, you are pointing out a very important area. This is one of the reasons why we have been unable to give an opinion on IRS' financial statements. On their financial statements they should show the amount of valid accounts receivable, and of that how much is actually collectible.

We have been working with them over the past few years to come up with a methodology for financial reporting purposes, of a point in time of coming up with an accurate estimate of that, which was a subset, as you are saying, of the gross amount that is in the accounts receivable inventory. So the reporting requirements under the Chief Financial Officer Act will provide the information that you are talking about, and will be independently audited.

We have been unable to come to a comfort level with those estimates of IRS, because there have been some errors that have been made in data input into the IRS area, which needs to be taken into account. For example, now we have reached agreement with them that all accounts receivable over $10 million, they will check the accuracy of the information, so when we take a statistical sample we can go in and verify that information.

But the answer to your basic question is already being addressed through the implementation of the financial reporting requirements under the CFO Act. We just need to get it implemented. And part of that is for IRS to have a detailed subsidiary record of their accounts receivable, which they do not have right now. All of the information is in the individual tax files, the master files; but there is not a ready inventory of tax debts that you would expect to see in a corporation.

But they are moving in that direction, and we are making additional specific recommendations to make it happen.

Chairman JOHNSON. Well, as they do review what is in their files and record it more accurately, or describe it more accurately, I think we all need to think about whether there is also some need to change the law so that we do not misdescribe dollars and leave the general public to believe that the bureaucracy is doing a worse job than it is.

Mr. DODARO. We will take a look at that issue.

Chairman JOHNSON. It does have problems, but it also has strengths, and we do not want to obscure the one with the other.

Mr. DODARO. Yes. Well, the other thing we are trying to do that I think will help address your question is to make IRS more swift to take action to collect the receivables.

Chairman JOHNSON. Right, without question.

Mr. DODARO. Because unless they move quickly, it becomes very doubtful that they can collect a lot of these in the future years.

Chairman JOHNSON. Actually, we do need to get back to that, and to your comments on the private sector testing, a collectible demonstration project.

But let me yield to my colleague, Mr. Coyne, at this point.

Mr. COYNE. Thank you, Madam Chairwoman.

Mr. Dodaro, can we take from your testimony here today that in no way have the reductions in the budget of the IRS been respon-

sible for the failure to implement some of the reforms and changes that you have recommended?

Mr. DODARO. Basically, the changes we have recommended, particularly in the TSM area, have been to constrain the spending in that area. So that some of the actions taken by the Congress have been consistent with the recommendations that we have made.

I think as IRS demonstrates the ability to handle additional spending in the tax system modernization or other modernization initiatives that they might pursue, the Congress should look to see that those justifications are well supported and documented by data.

But in most of the actions that have been underway, they were underway prior to this year's budget reductions. And we think if they can sustain the attention of it, they should be able to fix these problems with some of the current resources that they have.

Mr. COYNE. Ms. Ross, the legislation that was enacted last year relative to overpayments by SSI, do you think it is too soon to make a judgment about what the impact of that might be?

Ms. ROSS. I think it will take a little more time to understand exactly what happens. And let me explain why. You looked at groups that were particularly high-growth groups and groups with significant vulnerabilities. But for example, in the case of SSI children, the Social Security Administration has just within the past few weeks issued regulations about how they will now evaluate children. And I think it remains to be seen what happens when they have this new set of regulations implemented.

Our concern before was that the way the regulations were being implemented did not assure you that only children with really severe disabilities went on the rolls. It will take time to see whether the new regulations do as well as we hope.

The same thing applies to other cases of implementation, but that is the reason I think there is a little time that needs to go by before a final assessment can be given.

Mr. COYNE. So would the same thing hold true for the recent SSA administrative reforms? Are you contending that it is a little too early to judge what impact that might have on SSI overpayments?

Ms. ROSS. They have told us about things they are planning to do. I think we want to make sure that they follow through and that it has the desired results. So I think it is too early to make a final conclusion.

They certainly have talked about some things which would make improvements. We just want to make sure they get done.

Mr. COYNE. I wonder what exactly would GAO recommend be done, both in the short term and the long term, to address the SSI overpayments? Does it take more legislation or more administrative reforms? What is your recommendation on exactly what ought to be done relative to the overpayments?

Ms. ROSS. Well, first of all, we have just put SSI as a high risk, and so we do not have a lengthy list of recommendations. But we have worked on this program for some years, so we are ready to give you some initial suggestions.

The most important thing that could happen is that the Social Security Administration place higher priority on running this pro-

gram. If that happened, a lot of other things probably would fall into place.

Now, once they pay more attention, there are some administrative practices that need to be changed, and I suspect there are also some pieces of legislation, additional legislation, that will need to be passed.

But things that are already within their control are: Moving more quickly in online access, that I talked about earlier; moving more quickly to implement other methods for verification to assure the public that there is integrity in this program by doing as many continuing disability reviews as are required, and possibly more; and also, moving more of the SSI population through vocational rehabilitation and into the work force. So I think there are a lot of very specific things that are already available to be done.

Mr. COYNE. When you become aware of what legislative recommendations might be helpful, would you be in a position to come to this Subcommittee and recommend what they might be?

Ms. ROSS. Yes, sir. We already made one or a couple of recommendations about things that we think would improve the integrity of this program. They have not been on SSA's legislative agenda as yet, but we would be glad to make sure you know about those and others as we make them.

Mr. COYNE. Thank you.

Chairman JOHNSON. Let's see. Ms. Dunn is no longer with us.

Mr. Hulshof.

Mr. HULSHOF. Thank you, Madam Chair.

Ms. Willis, let me go to you. You do not need to go to your particular statement, but I will paraphrase. You mentioned that, regarding fraud detection, modernization is the key. And yet I am hearing through several of your testimonies that the IRS does not have the commitment, the management commitment, nor the technical expertise.

It seems that we are in a catch-22. What can you tell us in that regard, Ms. Willis?

Ms. WILLIS. Sir, I think that the first thing that the IRS needs to start with in that regard is their electronic filing, or what they are now calling their electronic commerce strategy. The key to addressing a lot of the issues that are associated with filing fraud is being able to identify up front, before the return is filed, or at least before the refund goes out, whether there is a problem with a particular return.

That is made a whole lot easier if that return is filed in an electronic format. So in addition to reducing the amount of paper and enhancing the quality of the data throughout the system that electronic filing brings, having returns electronically filed makes it a great deal easier for us to identify potentially fraudulent returns.

Once we have an electronic filing strategy and we understand how we are going to reengineer our processes to accommodate and support the strategy, we then will have a better sense of what the technical solutions are to addressing the issue.

And in doing that, there are a variety of places that we can look to, including the private sector, contractors, and internally to IRS. But it is going to take a sustained commitment to developing that

electronic filing strategy and then successfully building the technology to support it.

Mr. HULSHOF. Let me follow up on that question. Because in a recent statement by Treasury Deputy Secretary Lawrence Summers about the $4 billion—with a "B"—$4 billion of our tax moneys that have gone to the tax system's modernization effort—mentioning that of course that money was not entirely wasted, but at the same time adding that more problems could surface.

And we are talking about another half billion dollars being requested by the administration for this TSM project. And that is of concern to me. Is that of some concern to GAO?

Ms. WILLIS. The amount of money that we spend to modernize IRS is of concern to GAO. And I think, looking to the future, we are very concerned that IRS develop the technical disciplined processes that Dr. Stillman discussed in order to assure the Congress and the taxpayers that the money we provide is not only going to be well spent, but is going to deliver the benefits that the public has every right to expect.

Mr. DODARO. Congressman, if I might add to that, one of the things that the Congress did last year when they passed the appropriations bill for IRS was to require IRS to issue a schedule for implementing GAO's recommendations by October of this year. We have just been briefed by the IRS on their plans, and we are going to be evaluating their progress.

I guess my feeling would be that they need to address the underlying, as we pointed out, management and technical weaknesses, to be in a better position to spend effectively additional funding in that area. We are going to be evaluating that and providing the Congress our periodic assessments.

They are doing, or planning to do, many of the right things. But one thing we have learned about our high-risk initiative over the last 7 years is that plans and good intentions do not often come to fruition and, really, followthrough is the key. So that is why we are going to stay very closely to assessing IRS' ability to be able to do this.

In fact, we are going to be also starting an initiative to assess their technical ability to manage contractors. And Congress is urging them to go in that direction. So we are going to be watching that very closely, and we are concerned.

Mr. HULSHOF. One final question. Since Treasury and IRS took this "sharp turn approach" to TSM, is it true that over 1 billion dollars' worth of contracts involving 26 projects have been canceled during the last 12 months?

Mr. DODARO. I will ask Dr. Stillman to address that.

Ms. STILLMAN. We have not validated the precise numbers, but it is true that they have canceled some significant contracts. They canceled the DPS contract, after expending $280 million on it. They have canceled cyberfile. They have canceled some contracts. We have not verified the exact number.

Mr. DODARO. Our basic concern there is that the tools are now available to stop those types of projects much earlier in the process. And that is what our goal, IRS' goal, and the Federal Government's goal needs to be, is to not go forward with these multiyear projects. They need to go in incremental stages. And these are the best prac-

tices that we have learned from leading organizations that we are trying to get the Federal Government to implement.

At some organizations, like Xerox, any investment over $100,000 in technology is considered high risk. In the Federal Government it is a rounding figure. So I think we need to really make sure that those investment criteria are put in place. The IRS is trying to do that, and we are making sure they use good data to know in advance whether we are making good decisions, not several years down the road.

Mr. HULSHOF. As a final comment, Madam Chair, perhaps, rather than continuing to make these massive investments of our tax money, perhaps tax simplification might be something we should consider. Thank you, Madam Chair.

Chairman JOHNSON. Mr. Tanner.

Mr. TANNER. Yes, thank you very much, Madam Chairman. And thank you all for being here this morning. The testimony is very interesting. Let me ask Mr. Dodaro and Ms. Aronovitz, you all mentioned in your testimony that the fraudulent, wasteful claims and abusive billings and so on in the area of Medicare could be from $6 to $20 billion a year, based on 1996 outlays. What was your methodology in arriving at that number? And is that as close as you can come to the right number?

Ms. ARONOVITZ. That is a very, very difficult question to answer, because so much of fraud and abuse, first of all, is not detected. To detect fraud and abuse requires putting in systems that would then avoid unnecessary costs in the future, and that is very difficult to quantify.

Also, it is very difficult to quantify the different types of fraud and figure out what portion of an overall percentage estimate would be attributable to each type. However, studies and the work that we have done over the years have generally estimated fraud to be somewhere between 3 and 10 percent. And that is about as close as we really could come to giving any hard numbers in that area.

Mr. DODARO. One of the things, Congressman, that we are in the process of doing and supporting, the Inspector General at the Health and Human Services is conducting the first financial audit of the Department of Health and Human Services, under the expanded requirements of the CFO Act.

We have taken, along with them, a nationwide sample of Medicare claims, and we are now testing that sample, which is statistically projectable, to determine to what extent there would be errors in there. And we are hoping that the financial audit requirements will shed some more light on this information.

It is also important in some of these programs that we reach agreement between the Congress and the administration on what is the appropriate level, and how well are we doing in bringing that level down, which goes to the setting of good performance measures to track progress. Right now the best we have is this range of estimates, but we are hoping to perfect them as we can implement some of these reforms.

Mr. TANNER. Your answer anticipated my next question. That is, how do we do a performance-based measurement of reducing waste, fraud, and abuse, if we don't know where we are starting from?

And any work you all could do and provide us on that issue would be very much appreciated.

Mr. DODARO. I think that the results of this financial audit will be available this summer. And I think at that point we can be able to be in a position—again, we are supporting the HHS IG on this—to be able to share that with the Committee.

Mr. TANNER. Well, there is a lot of political rhetoric around waste, fraud, and abuse as it relates to the government. And it seems to me the better definition we can come up with in that area, the more enlightened the public will be about what we are talking about; so that the notion that, if we could just take waste, fraud, and abuse out of the government, we could magically balance the budget overnight would be somewhat refuted.

Let me ask in this connection, what are your concerns, or what concerns did you find, with respect to the program in the HMOs that are in vogue now?

Ms. ARONOVITZ. I think the two biggest concerns we have right now—one has been talked about very, very much, and that has to do with underutilization, or the assurance that people who are in HMOs are getting all the services they need, within the framework of the services they are entitled to.

There is another issue that has to do with giving beneficiaries all the information that they possibly can have to compare HMOs in a particular market. We found that HCFA collects very interesting data on the premiums and the benefits of risk contract plans within a certain market. However, not unlike FEHBP and even employers, they do not share that information with beneficiaries.

So if you are a beneficiary, let's say, in Miami, and you want to join an HMO, you have to call, number one, a toll-free number to identify the names of all the plans that would be in Miami. Then you have to call each plan individually, obtain their brochures. Once you receive those brochures, you have to pore over them, to try to get comparable information about their benefits and premiums. And HCFA already has this information.

Now, HCFA says that it is going to start sharing this electronically on the Internet. But we feel that that is just a very small step, because, clearly, my mother and your parents typically are not that able to access the Internet to get their information.

We think that HCFA assumes that that information will mostly be used by State and local governments, advocacy groups, and maybe insurance counselors. But we think that information, along with other types of performance measures—like disenrollment data, which right now we think is an immediate proxy for beneficiary satisfaction—HCFA has that type of information and should be able to disseminate it to its beneficiaries. Those are the areas that we think are the most critical right now.

Mr. TANNER. May I ask Ms. Ross a question, Madam Chair?

Chairman JOHNSON. We are going to come back for a second round.

Mr. TANNER. OK.

Chairman JOHNSON. But you can do it briefly, if you have to leave.

Mr. TANNER. Well, I just wanted to ask you, very briefly, you mentioned in your testimony, Ms. Ross, that online access is one

possible solution to the overpayment problem in the SSI Program. We have, I think, as you know, a pilot project ongoing in my State of Tennessee. And I was wondering if you had reviewed the progress being made there. And what is your understanding of the success, relatively speaking, of the program so far in Tennessee?

Ms. ROSS. Yes, the program in Tennessee was the basis for our work on using State data and linking it with SSA. And on the basis of the information we collected in Tennessee, we were able to do some estimate of some national cost savings. So it sounds very promising, from what happened in Tennessee. And while SSA is moving forward, we just do not think they are moving expeditiously enough.

Mr. TANNER. But the realtime match ups of the dates that are important in the SSI Program are being done in Tennessee more expeditiously, may I say, than they are nationally? Is that correct?

Ms. ROSS. Tennessee is the leader. There are other States that are now beginning to put up these systems, but Tennessee was the first and it is the most complete.

Mr. TANNER. Thank you. Thank you, Madam Chairman.

Chairman JOHNSON. Thank you. Mr. Weller.

Mr. WELLER. Thank you, Madam Chair. And I would like to direct my questioning to Ms. Aronovitz. Over the last couple of years, with the impending bankruptcy of Medicare, I have had extensive conversations with many seniors in my district. I have had over 80 meetings, town meetings, or Medicare town meetings, and even talked with my own parents about Medicare. And of course, it always seems that the meeting usually, unless you really control the subject—most seniors want to talk about the examples of waste and fraud which they feel they have personally experienced in Medicare.

And you were discussing with Mr. Tanner the estimated $6 to $20 billion that the GAO estimates this past year was waste and fraud in Medicare. And I guess, to start with, I was wondering what areas in Medicare do you see where there are the greatest examples of waste and fraud? What are some examples that you have found?

Ms. ARONOVITZ. I think some of the areas are ones that are benefits of the program that have grown the fastest, and that is areas of home health and skilled nursing facilities and others. There are several areas where there is so much vulnerability because of the volume of Medicare beneficiaries in one location. And it is very important to make sure that claims are reviewed, both at a prepayment and a postpayment stage.

One of the biggest problems we have had was that HCFA has really lost the funding for program safeguards. And what we mean by that is reviewing claims before checks are cut, and even afterward, has really declined substantially over the last 7 to 10 years. HIPAA restores a lot of that money. And we think that, with hiring a lot more investigators and auditors and being able to perform what we call focused medical review—that is, to look at national statistics and then try to identify those contractors that are paying benefits that are out of the norm for that area—it starts giving HCFA an opportunity, or the contractors an opportunity, to focus in on aberrant providers or certain conditions in an area that could

potentially be a problem of fraud or abuse. So a lot of it has to do with having the money to spend on better oversight and to do better focused medical review on claims that are being paid.

For instance, let me give you one example in home health. The home health claims have increased substantially over the last several years, since 1989 when the benefit became a little bit less restrictive and the number of home health agencies have really increased.

It used to be, in 1984 and 1985, where HCFA was being able before they paid a claim to review almost over 50 percent, probably around 62 percent of all home health claims. Now they are lucky to be able to review 3 percent of those claims. And when physicians are not very involved in the plans of care—they sign off on the plans of care but they are not really that involved in overseeing what the home health agency is actually doing for the beneficiary—very often we find in that particular program that there is a lot of overutilization. Or in fact, sometimes the beneficiaries do not even qualify because they are not actually homebound. And with limited funds it was very difficult for the home health agencies and HCFA to assure that the beneficiaries met the qualifications. But there are a lot of different types of problems.

Mr. WELLER. Well, this past year, with the Health Insurance Portability and Accountability Act——

Ms. ARONOVITZ. Right.

Mr. WELLER [continuing]. Of course, we increase the opportunity for HCFA to contract with utilization review firms.

Ms. ARONOVITZ. Utilization.

Mr. WELLER. And of course, that legislation was signed into law in August. But have we had time to see whether or not that initiative has been working, now that that is being implemented?

Ms. ARONOVITZ. We have indications that the OIG is going forward in that regard. And we are very hopeful that utilization review companies that specialize in focused medical review and in performing comprehensive medical reviews will in fact increase their effectiveness. And also, these companies use advanced technologies and software that is on the market that could substantially help them identify areas of abuse and fraud. So we are very hopeful, but it is still very early.

Mr. WELLER. Well, you have indicated you have seen, if you look back over the last 10 years, a reduction in the review of the claims. And of course, with the initiative that we passed last year, there is an increased opportunity. What percent of claims do you project will be now reviewed as compared to last year, as a result of this?

Ms. ARONOVITZ. We are not sure yet. We think that there are a lot of different activities that could be done much more frequently. For instance, cost reports which are submitted by institutional-type providers in part A are an area where HCFA or the contractors, the intermediaries, have really, really held back, because they have not had enough money to audit these institutional providers. They will be able to do that to a much greater extent.

The actual number of claims that will be audited at this point we are not sure of. But there will be entities that will be able to have their cost reports audited much more fervently. And also, focused medical review, where you could have more money to identify

outliers, for particular providers that are outliers, is very, very important; probably more so than just reviewing claims as they come through. You want to try to identify those that look like they potentially could be problems. And HCFA will be able to concentrate more on doing those types of reviews

Mr. WELLER. Thank you, Madam Chair. I see my time has expired.

Chairman JOHNSON. Thank you. I think it is important to note that, as we press down the length of stay in hospitals, we expected the number of home care cases to increase and the length of home care to extend. So some of this is positive in reducing overall costs.

Second, I think it is very important to recall that there was a court case, a judicial decision, I think it was 1989——

Ms. ARONOVITZ. Yes.

Chairman JOHNSON [continuing]. That took off all the constraints on home health services that the government to that point had been enforcing. I mean, the law was very clear when you were and when you were not able or eligible for home health care services. And that judicial decision really prevented government from exercising a lot of commonsense constraints that it had been exercising.

The Health Subcommittee of Ways and Means is working on how to constrain growth in this area through reforms in the payment system that will put the onus and the burden, and also the financial risk, on the agency, so that they do not get rewarded for providing unnecessary services. But it is a difficult issue because some of what we see happening is desirable, and it is a response that we provoked through other payment policies to reduce the cost of Medicare. So I just wanted to make sure——

Ms. ARONOVITZ. Absolutely.

Chairman JOHNSON [continuing]. To put your words in context. Thank you.

Ms. Thurman.

Ms. THURMAN. Thank you, Madam Chairman. To reiterate, I remember that debate. In fact, we thought that that would reduce the cost for payment. Nonetheless, certainly need to see numbers.

But let me ask this question. It is my understanding that some of this information has been going out to doctors, and they have been reviewing some of the overutilization. What results have we seen from that? Would GAO recommend that all doctors receive that information?

Ms. ARONOVITZ. Yes. We think that is a very positive step. One of the problems in home health care is that the physicians have not traditionally or typically been that involved in the plan of care. Clearly, they have signed off on it, but they are sometimes surprised to hear of the level of services that are being provided to their patients.

So, yes, with making them more aware of what services are being provided, we believe they would be much more careful about what types of services they are actually prescribing.

Ms. THURMAN. In that context, too, now that more people are getting into the home health care business, particularly hospitals and other places that are just moving, do we see a concern there? Or are there some safeguards in place so that these numbers will not escalate again? I mean, are we putting any kind of restraints on

what they can or cannot do, or are we looking at the kinds of things they are offering?

Ms. ARONOVITZ. Yes, I think we are very concerned about these costs rising. I think what you are referring to is that the proprietary home health agencies have shown higher utilization per beneficiary than either voluntary or government types of home health agencies.

The one proposal that the Subcommittee on Health is considering is the prospective payment system approach to home health agencies. There are two concerns there that we probably feel should be entered into the debate about that, and one would be to define the unit of care properly so that home health agencies are reimbursed for their fair amount of expenses and, at the same time, they do not have a windfall by having a visit end up being 10 or 15 minutes when the unit of care would be defined as an hour, let's say.

The other concern about that would be to make sure that HCFA's database that includes the home health payments that are going to be used to calculate the payment rate is accurate. Because that payment database right now has a lot of inaccuracies, or payments that they have made that would probably have been denied had those claims been reviewed. But we think this is definitely a very important consideration and proposal, and an approach to look at.

Ms. THURMAN. In your opening remarks, you talked about how HCFA ought to better target their managed care dollars to reflect the cost in different geographic areas. Is this an issue of particular interest, and can you explain the GAO's recommendation? I have to tell you, this is a major issue in Florida because it affects the beneficiaries simply because of where they live, and also the effect of having doctors participate.

Ms. ARONOVITZ. Sure. This is quite complex. I will try to give a pretty simple explanation, if I can. The risk contract program requires HCFA to figure out how much to pay health plans based on the fee-for-service beneficiaries' experience. So right now, if you have people in an HMO, their experience does not count when you try to figure out how much to pay a plan; it is the fee-for-service people.

Studies have shown that there is about 10 percent of Medicare beneficiaries now that are in risk contract programs. That 10 percent seems to be, on the whole, more healthy than those that remain in fee-for-service. So therefore, it is the 90 percent "more sick" people that would be the basis on which you would then pay an HMO.

We have found that in some locations, in many cases, the HMO therefore has what we say is excess payments. They are getting more money or a higher capitation payment than they really need to support that particular beneficiary. We have made a recommendation regarding the county rate. It does not address the risk adjusters, which are basically sex, age, whether you are in an institution or not, whether you are working or not. But they are very gross types of adjusters.

Until a long-term risk adjuster can be developed—and it is a very, very difficult challenge, and one that HCFA has been working on for many, many years—we suggest that you include—we have a methodology where you can include the people who are currently

in the HMO as part of the overall beneficiaries when you calculate the county rate. In other words, the healthy people in an HMO, in addition to the people in fee-for-service, would all be counted. So it would help reduce excess payments a little bit.

Ms. THURMAN. I see my time is up.

Chairman JOHNSON. Yes.

Ms. THURMAN. Thank you, Madam Chairman.

Chairman JOHNSON. Actually, because two members have pursued relatively the same issue, let me ask you a historical question that I think pertains to this. In the eighties, HCFA allowed—because you make the comment that the Health Insurance Portability and Accountability Act gave HCFA additional flexibility to contract with utilization review firms. Now, in the eighties, they gave their fiscal intermediaries, the directors—those are the people who pay all the bills, so there will be an intermediary that covers a whole State. Some of the big States may have two intermediaries, but it's rare. Usually, at least in New England, there is one that covers most of New England. And HCFA gave them the directive to better screen for utilization.

I am aware of an instance in which, in one State in a 12-month period, $18 million was saved through better utilization. Now, that was no more money, and no more people; just screening for utilization. Well, needless to say, some of the providers did not like the new screen. And finally, because this was in the eighties and things were a little different and we had not had some of the experience we have had since, the screens were withdrawn.

But why do we not look at the cost effectiveness of that experience in the eighties, particularly when we have given them more people? We need people to look at managed care, to look at the issue of access and timeliness. Those are the kinds of intense medical reviews that only a person can do. But why do we not go back to giving fiscal intermediaries more responsibility for utilization of review screens, especially since the whole science of that is far more advanced than it was in the eighties?

Could you comment on why they dumped that and whether that was wise? And do you think we should use that approach?

Ms. ARONOVITZ. We could not agree with you more. Back in the eighties the contractors and the intermediaries would say that they had a lot more money; that to develop medical policy, which is the basis for then screening claims to decide whether or not you are going to pay them, takes money and it takes a lot of time on the part of the intermediaries. And they need to be reimbursed for that.

And the way the funding to intermediaries and carriers worked, or contractors, was that the amount of money that HCFA had to process claims was one pile of money, let's say. It was not earmarked for individual activities, like claims processing and then a certain amount for program integrity. It was all one. So of course, HCFA had very strict rules on how fast claims must be processed. So that was their first and highest priority, and you wouldn't blame them for that. But then after that, whatever money was left then they could divide that out among program safeguard activities, and other activities like that.

Back even in the early nineties, and actually in the last 2 or 3 years, we have issued several reports showing that there is commercial software out there that does things like artificial intelligence, fuzzy logic. We issued a report that looked at the flexibility that carriers could have if they have a little bit more money. And we showed that they could collect an extraordinarily large amount, or not pay inappropriately a large amount of money, with just a few extra cents per claim in their budget.

So that is why for the last several years we have been trying to see if we could restore, or have Congress restore, some of the money for safeguard. And now it is being earmarked for this purpose, which we think is a very positive step.

Chairman JOHNSON. Thank you. If you would get me that report, I would appreciate it.

Mr. English.

Mr. ENGLISH. Thank you, Madam Chair.

Ms. Aronovitz, I was curious, in your report you noted HCFA's failure to package or disseminate the information it has at its disposal about HMOs for consumer use. This is a very serious issue in my area, because we do not have a lot of experience with managed care, many of the communities in my district. And seniors, when I go out among them, ask me about the latest products that they have received information about. What do we need to do to provide seniors with better information about HMOs?

Ms. ARONOVITZ. You know, it is very interesting. There is a lot of information that HCFA has already. It is just not packaged. It is used internally, but it is not really packaged for public consumption. And it is not set up in a way that would make it user-friendly for beneficiaries; nor is it distributed to them.

For instance, if we could just get HCFA to consolidate information for a particular market on the premiums and the benefits provided by each plan, then seniors or beneficiaries could look at one piece of paper and compare what they need, just like we do in FEHBP or in other programs. You could choose a plan much more readily, if you understand better what the premiums and benefits are.

But way further than that, a proxy for beneficiary satisfaction really is disenrollment rates. And in a particular market, we found—for instance, in Miami we found that the disenrollment rate among plans could range anywhere from 5 percent a year to 30 percent a year, or even in 3 months. So if in the first 3 months the beneficiaries are leaving at the rate of one-third, then clearly something is wrong with their satisfaction in that particular plan. And someone else who knows that might think twice about joining that plan.

There is one other thing that HCFA is doing, and that is that they are developing part of the HEDIS, the employer performance measurement information system. They are going to have, starting with plans that renew or sign up in January of this year, a Medicare component that will have some process measurements, like how many screenings for certain kinds of conditions, and preventive care activities that different plans have. And they could disseminate that, also.

Mr. ENGLISH. Thank you very much.

Ms. THURMAN. Mr. English, if you will yield for 1 second?

Mr. ENGLISH. Certainly.

Ms. THURMAN. In Florida, at the end of next year, they are actually going to put out a report card, so that all consumers will have in place a comparison analogy of all of the plans that are within those areas. And I will be glad to share that with you.

Mr. ENGLISH. I would be delighted. And I am also glad to be reassured that Florida is such a progressive State in this regard.

Let me say, Ms. Willis, I was curious, in the report on accounts receivable there is an indication that the IRS has taken the position that the 10-year statutory collection period generally precludes them from writing off uncollectible receivables until that period has expired.

Now, I am an old green eyeshade type. I used to be a city finance officer. I think that is an interesting position. Do you concur with it? And I was wondering if you can offer us any notion of how much the accounts receivable inventory is made up of old accounts that will never be collected?

Ms. WILLIS. Let me answer the last part of your question first. At one point IRS used to attempt to segregate out how much of the current accounts receivable inventory was a result of extending the statute to 10 years. They no longer do that, so we do not have that number.

The numbers that we do have are on things that are currently not collectible as IRS defines them, and that could include hardship cases that may change over time. So it is very difficult to say of the total inventory what part of it we would never expect to collect, given potentially changing circumstances.

In terms of the 10-year statutory rule, you are correct. IRS generally interprets that they must keep those accounts on the books until the statute expires. I do not believe GAO has taken an official position on that. But as we discussed earlier, part of the issue here is not what is on the books, as much as how it is reported and the fact that if the information is reported within acceptable accounting standards you will be able to see how much of that falls into each of the various categories of the accounts receivable.

Mr. ENGLISH. Thank you. That is most helpful. Thank you, Madam Chair.

Chairman JOHNSON. Mr. Watkins.

Mr. WATKINS. Thank you, Madam Chair.

Mr. Dodaro, I have been interested in a lot of testimony here, but I would like to shift just a little bit. Do you have oversight of the Bureau of Indian Affairs?

Mr. DODARO. GAO has the ability to review the BIA, yes.

Mr. WATKINS. Could you give me a current status? I know 1 or 2 years ago, a couple of years or so ago, they came up with about a $2 or a $2½ billion or so shortfall. They were in disarray; couldn't put it together. You can give me a report, to my office or to the Subcommittee here, too, but could you give me a status of that?

Mr. DODARO. I am sorry. I——

Mr. WATKINS. A shortfall of about $2 billion or so over at the Bureau of Indian Affairs.

Mr. DODARO. OK. This is for their current operating funds, or for settlement? I am not that familiar with it.

Mr. WATKINS. A big report that came out in the papers just about maybe a couple of years ago, that there was a shortfall.

Mr. DODARO. That related to the trust fund activities?

Mr. WATKINS. Yes.

Mr. DODARO. We have been doing a lot of monitoring of that. I was not prepared to talk about that today. I will give you some information on it. We have monitored the settlement process—or not the settlement process; the reconciliation process for the trust funds, and in the past have recommended that they move to a settlement type of an arrangement. But I can give you some information for your record.

Mr. WATKINS. I would appreciate your providing that for the Subcommittee, if Madam Chair would like that, and also for me at my office, if you could. I appreciate that very much.

Mr. DODARO. Sure.

Mr. WATKINS. Let me ask you, my understanding is that one of the difficulties you found is that your office does not have any jurisdiction on doing an auditing on Indian tribes, Federal funds that go to Indian tribes. Is that correct?

Mr. DODARO. I would have to go back and research that a little bit. But I think we have the ability to go wherever the Federal moneys go. I mean, we do not normally do auditing of individual tribes, though. We pretty much leave that up to the Department of Interior.

Mr. WATKINS. I have not seen any actions or any footprints of GAO with the tribes. I have been told that GAO basically does not have jurisdiction or the power to do audits of the Indian tribes that consider themselves sovereign nations, and so forth. But I would appreciate having that.

Mr. DODARO. I will give you that information, along with the package of information we have been doing on BIA.

Mr. WATKINS. Yes, let me know the status of that and what you might have found in some of those areas of fraud and abuse, so to speak, or the disarray they have had over there.

And Madam Chair, in the break throughout my district I spent over 3 hours meeting with home health care people. I have been a believer in home health care, but I have seen and been quite concerned about the explosion of the number of home health cares in some of these communities, small communities, 14 to 15. All the downtown offices and buildings that were empty are now filled with home health groups fighting over patients.

And so I met with them. I said they really, truly are abusing and jeopardizing a good program, an excellent program that I am for, and trying to keep our parents and grandparents and all there.

Madam Chair, the number one thing they said is, "We want, if at all possible, to get investigation money for fraud and abuse." I was extremely pleased with the professionalism of two or three of the people that I had there. They feel like, for every dollar spent on investigation and fraud abuse, they could probably make $10 to $15 from such activities.

So they had a lot of other suggestions, but one of those is to definitely get more investigative power in there, because I would like

to see us keep that program. I think it is a great program. I am alarmed about the cost. I know there are various factors that go in there. But when you see a shed where a sign is put up, "Home Health Care, A–Z," whatever it may be, you think, well, are we getting the kind of services that we have got to have? Are we professional? And I hope we can remedy that in some way.

So I was pleased that they asked, though, for more investigation on fraud and abuse dealing with home health care. They want to get it established as a professional group. So thank you, Madam Chair.

Chairman JOHNSON. Thank you very much. It certainly has been my experience—and I work closely with the home health care industry—that the responsible providers in the home health care industry have been as interested as any single group in our doing something, because they see the fraud first hand. And by the time they report it to us and we get the Inspector General out there, the fly by nighters close up and move on someplace else, and go back into the same fraudulent delivery system.

So it is a very big problem, and I would certainly hope those new investigators will be focused on home care, and not on the intermediary activity, because we have some good ways we can go in that area that we actually have experience in.

There are just a couple of questions that I want to ask, and I will give other people a chance. First of all, Ms. Willis, your testimony in regard to information security in the IRS is starkly damaging. The fact that the IRS cannot effectively prevent—and you make this statement in your testimony—cannot effectively prevent or detect unauthorized browsing of taxpayer information, and cannot ensure that taxpayer data is not being improperly manipulated for personal gain, is astounding.

Now, we have had some cases of this reported in the last few years, of inappropriate browsing. But why, at this time in its history—why cannot the IRS detect unauthorized browsing of taxpayer information and ensure that taxpayer data cannot be manipulated for personal gain?

Ms. WILLIS. Madam Chairman, let me turn this question over to Dr. Stillman, who has been the lead on that work, and I think she will be able to answer your questions.

Chairman JOHNSON. All right.

Ms. STILLMAN. There is a pair of reasons. One is a fundamental shortcoming, as we talked about before, in the technical discipline that IRS uses in building and fielding its systems. One of the things that IRS lacks is a security architecture.

And what that means is that they do not have in explicit fashion a statement of their security requirements and a mapping of those requirements onto the security features of the system. They cannot tell you from top to bottom what security they need and how the individual systems will provide that. It does not exist.

Chairman JOHNSON. And when did you first ask them this? When did you first point this out to them? How many years ago?

Ms. STILLMAN. Several.

Mr. DODARO. Part of this surfaced as a result of our first financial audit done under the CFO Act, which was back in 1992, that timeframe. And we have issued a number of reports on this.

We have kept most of those reports restricted, limited to official use only. We have given them to key congressional committees, and so forth, but we did not want to publicize too broadly some of the vulnerabilities. And I think this is an area that, if the Subcommittee wants to get into it in a closed session, I would recommend it.

We have just issued another report just recently, and this is an area that Senator Glenn on the Senate side has had us—you know, he has been the champion of the CFO Act on the Senate, and he has had us follow this for a number of years now. And we look at it every year, as part of our financial audit responsibilities, as well.

It has been a continuing problem. They have tried to take action. But one of the reasons we put information security on the list for governmentwide purposes is because it does not get the attention that it needs. Everybody is interested in giving access out broadly, and security is often not thought about in the process. And as a result, a lot of our information systems across the government, unfortunately, are in a very vulnerable state right now.

We have also made recommendations to OMB that they act, in addition to recommendations we have made at individual agencies. Part of the Clinger-Cohen Act was to establish a chief information officer council across the government. We have urged OMB to make information security a top priority of that council, so that they can move forward.

But there are many things IRS could do. We have had many recommendations. And I think some impetus from this Subcommittee to have them be accountable would be a good idea.

Chairman JOHNSON. Thank you. And we will arrange that briefing. Is there anything else? Because I did interrupt you. I just wanted to get in context your comments in the historical perspective of GAO action, because I knew that this is not the first time you had brought this forward.

Ms. STILLMAN. I think it's been fairly well covered. The only additional statement that I was going to make, the only additional consideration, is that in cases where IRS does make an effort to institute security, those efforts have an ad hoc nature to them, and they tend to be incomplete. So that whereas IRS has a system to monitor and attempt to detect browsing on some of its access systems—on one of its access systems—it does not on the others. And so what they do tends to be incomplete and ad hoc.

Chairman JOHNSON. Thank you.

Ms. Aronovitz, let me just ask you briefly a couple of other questions. HCFA is about to implement a Medicare transaction system to try to reduce fraud. You comment that there are three major management and technical risks associated with that system. Would you just briefly describe those risks and their potential to prevent the Medicare transaction system from achieving its goals? Or whoever would like to answer.

Mr. DODARO. Yes, Madam Chairman, I have Joel Willemssen, who is our Director, looking at information technology systems at HHS. And Joel has been tracking the Medicare transaction system. I would ask him to respond.

Chairman JOHNSON. All right. That will be fine.

Mr. WILLEMSSEN. Madam Chair, the risk can be pretty much broken down into three areas. First, HCFA has historically had

trouble with the contractor finalizing its requirements for the Medicare transaction system.

Second, we have historically had a lot of concern with HCFA's cost-benefit analysis for the system, and we have continued to push for that analysis to be complete. The third risk that continues to exist that we still have concerns about is that there are overlapping development bills within the MTS schedule. And given this, there is a lot more risk that the system will not be developed on time and provide the needed improvements that are necessary.

Mr. DODARO. Yes, we are currently continuing to monitor the MTS implementation. HCFA has responded to some of these concerns, is trying to make adjustments. But we will be issuing further reports on this topic.

Most of the areas—or, indeed, all of the areas that Joel mentioned, in terms of requirements, cost-benefit analysis, and so forth, are what this new information technology reform legislation is designed to fix. That requirements area, in particular, is one where a lot of agencies have gone awry. This was a critical problem in FAA's failed efforts to modernize air traffic control systems.

So we are very concerned about that, and also the cost-benefit analysis. I mean, they need to demonstrate up front that this is going to be beneficial in terms of reducing fraud, providing better service, enabling them to better have financial reporting under the CFO Act, and so forth, and it is going to be worth the benefit. And a lot of times, that type of analysis has not been done properly, and that is why you have in the case of some of the IRS tax system management projects, after 7 years people say, Well, it is not worth it. And so we are watching that very closely in MTS.

Chairman JOHNSON. Thank you.

Mr. WILLEMSSEN. Madam Chair, if I may add, one other associated risk is that full implementation of the new Medicare transaction system will now not occur until after the year 2000, and therefore——

Chairman JOHNSON. After the year 2000?

Mr. DODARO. Right.

Mr. WILLEMSSEN. That is correct.

Chairman JOHNSON. When we are conscious of the volume of fraud in this program? That is remarkable.

Mr. WILLEMSSEN. Yes. And the concern that we have, and the risk that we have to monitor, is the fact that the existing "A" and "B" systems therefore will need to continue to run past the millennium, and we need to therefore make sure that they are millennium-compliant and that they will be able to handle claims appropriately past that date.

Mr. DODARO. One of the other things we have suggested is that they test the use of commercial off-the-shelf technology that other carriers use to better detect fraud up front. And we are at least encouraged they are testing that now. And they have also engaged Los Alamos Laboratories in helping develop better fraud-detection technology. So we think those are two good efforts, but it took a couple of years for us to get them to agree to do that.

Chairman JOHNSON. Ms. Ross, in your testimony you note that thousands of SSI recipients in nursing homes continue to receive

full benefits, resulting in millions of dollars of overpayments each year. Could you comment on that?

And could you comment on the further information you provide: That many recipients live in households where the median income is $40,000; 25 percent where the incomes are $64,000; and very few actually live below the poverty threshold, only 7 percent?

Now, since SSI is an income-related program, these statistics surprise me, and the fact that money is continuing to flow to people who are in nursing homes, which Medicaid is paying for. If they are, presumably, SSI-eligible, they are Medicaid-eligible. This concerns me.

Now, these are remarkable facts you bring out in your testimony.

Ms. ROSS. I can expand a little bit on the nursing homes information. When people move into nursing homes, SSI ought to be notified of that fact so that the payment can be curtailed.

Chairman JOHNSON. Just stop there 1 minute. You know, we pay half of the Medicaid bills. I mean, cross-checking does not take a rocket scientist to think up. If we do not have the names on the half of the money that we pay, the State certainly has the names. I mean, I just cannot imagine that so much of this is going on, when the data is terribly available.

Ms. ROSS. You know, we should have come to you and asked you about this before we did our whole study, because we are going to come out with a recommendation of exactly what you said; that the State Medicare data ought to be matched with the information from SSI.

Chairman JOHNSON. Are you going to come out with that early enough so it could be in action this session?

Ms. ROSS. Yes. It should be out in 2 to 3 months—2 months. But we can tell you all the information any time you wish.

Chairman JOHNSON. And what about this business of SSI recipients who actually live in a household of some affluence? I mean, we went through this with home health services in a pilot project in the seventies. We did not look at the household income, and we were providing enormous services to people who were living in the homes of their doctor-son. I mean, so is there any consideration of household income under SSI? And if so, why is it not implemented?

Ms. ROSS. There are considerations for the household in which you live, but there is not sufficient checking of the assertions that individuals make. That is one of the most difficult areas for SSA to check on, but one that they clearly need to spend more time on.

Chairman JOHNSON. So the law does require it; it is not being done.

Ms. ROSS. That is right.

Chairman JOHNSON. That is really appalling. OK. I do not want to take too much time, just one little last question that I hope can be answered very briefly.

Ms. Willis, you point out that the independent contractor sector is a sector in which there is low compliance in regard to tax obligations. We have discussed and we have held hearings on this subject. The executive branch is making some proposals. We hope to come back.

Would brighter lines help? We see very high compliance in the independent contractor sector where 1099s are involved. There are

more situations in which we could require 1099s. We could also define independent contractor considerably more clearly. Would those kinds of things help with compliance?

Ms. WILLIS. Better defining independent contractors would definitely help compliance, and would also ease the burden for employers, in terms of how to classify the people who work for them.

But changing how you define an independent contractor does not address the issues related to withholding or information reporting. And those are the two features of the system, when someone is an employee, that tend to enhance their compliance.

When you have withholding on wages, you have a compliance rate up above 95, 96, even to 99 percent. It drops significantly if you don't have withholding. If you have information reporting on different types of income, that also enhances compliance.

So if we could design better systems for making the income that independent contractors earn more apparent to the IRS, it would enhance compliance.

Chairman JOHNSON. Yes. We do not require now that corporations provide 1099s to their independent contractors.

Ms. WILLIS. Right.

Chairman JOHNSON. And those are the kinds of things I think we could quite easily do.

Ms. WILLIS. Right.

Chairman JOHNSON. Thank you.

Mr. Coyne.

Mr. COYNE. No questions, Madam Chairwoman.

Chairman JOHNSON. Mr. Tanner.

Mr. TANNER. Thank you very much, Madam Chair.

May I come back to Ms. Ross for just a moment? Getting back to Tennessee's experience with the online transfers of information with respect to the overpayment problem in the SSI Program, it is my understanding that some States have been reluctant to make that information, or that data, available to the Social Security Administration. Do you know anything about that ongoing situation?

Ms. ROSS. I think a lot of States have been reluctant to do it online. Most of the information gets sent sooner or later to SSA in these sometimes rather dated computer matches. But they are somewhat uncomfortable, or they talk about their discomfort, with online access. And I think that is a matter of education.

Obviously, there are some security issues here. And we have had people from our systems group look at some of the security issues related to online access. But once the State is assured of that, I am not sure what other issues remain.

Mr. TANNER. Well, my point is that if we had better coordination, it seems, we could get more real time with the recipient of an SSI check returning to work. As I understand it now, sometimes that can go on for 10 months.

Ms. ROSS. Right.

Mr. TANNER. I guess, theoretically, 11 months and 29 days, before the systems that are in place here could catch that overpayment if the check is otherwise sent out. And the more we compress that real time, through quarterly reports on unemployment figures or however, it seems to me, the better we can gain the efficiencies of the system for which it was intended.

And if there is a reluctance in the marketplace of States to participate in a more efficient way of doing things, it seems to me we might come up with some incentives or otherwise fine tune the systems to try to gain that realtime match. Am I making sense?

Ms. ROSS. Well, I agree. First of all, I certainly agree that it has a tremendous potential for preventing overpayments, which is the goal; not to try and figure out ways to collect them once they have occurred. We have not looked at the issue of incentives; nor have we talked with a large number of States about the basis for their reluctance. But as we do that, I would be glad to keep in touch with you, to talk to you about it.

Mr. TANNER. Well, getting back to my original point to Mr. Dodaro about setting a baseline from which we can judge ourselves as to how we are doing with respect to this whole question of waste, fraud, and abuse, that is very important; not only, I think, from just doing our jobs well, but it is also important from the perceptual standpoint with the citizens of this country who understandably get a little bit perturbed when they see or perceive waste, fraud, and abuse going unaddressed. So any suggestions you can make along that line would be most welcome.

Ms. Willis, you said in your testimony, and following up on the Chairlady's observation, that computer security management at the IRS is an ongoing problem. You state that there is not a proactive program in place down there to monitor, anticipate, and otherwise address this issue. What steps, if any, have you discussed with them about putting a positive constructive program in place, rather than simply being reactive, as your testimony suggests to me?

Ms. STILLMAN. We have indeed, and IRS does recognize the importance of security. They have said they are committed to putting a proactive program in place, and we will monitor them as they try to do that.

Mr. DODARO. We have spelled out, Congressman, some of the specific things that IRS needs to do.

Mr. TANNER. So you have?

Mr. DODARO. We have done—they need to do risk assessment, have disaster recovery plans, limit access to only people that really need access to particular systems. So we have spelled out in pretty good detail——

Mr. TANNER. So this is more than just an observation with no——

Mr. DODARO. Yes.

Mr. TANNER. OK.

Mr. DODARO. Right. I mean, we have made this recommendation in great specificity. And plus, there are already well spelled out in some of the Federal regulations what the necessary requirements would be for a security system. This is not a complicated issue. The techniques are well known.

Mr. TANNER. And they are onboard with this?

Mr. DODARO. They have agreed with the recommendation. It is a matter, like many things that we find at the IRS, of lack of followthrough and implementation. That is all that is required here.

Mr. TANNER. Is there anything we need to do here to assist in that effort? If you have any suggestion along that line, that would be welcome.

Mr. DODARO. We do. And I think the basic recommendation I would have now would be to have them up here to report to you, to this Subcommittee, what they are doing to fix this problem. And we can provide some assistance. But I think some interest on the part of Congress will do a lot to spur them forward. Thank you.

Mr. TANNER. Thank you.

Mr. HULSHOF [presiding]. Ms. Thurman.

Ms. THURMAN. Thank you, Mr. Chairman.

In Florida, we really have done some interesting things over the last couple of years. In Florida, the legislature and the Governor put into place an antifraud program to target areas of the greatest abuses in the Medicaid Program. Some of these included home health, durable medical equipment, and transportation services. Additionally, they required a $50,000 surety bond by new providers.

They also required all current noninstitutional providers to reenroll with the State Medicaid office, which actually demanded more detailed information from the providers as well as background checks conducted in cooperation with the Florida Department of Law Enforcement.

Actually, the results have been pretty interesting. We have seen a large reduction in DME providers, from 4,146 to 1,565, which is a pretty good decrease. Interestingly it has not broken any of the services to the beneficiaries.

We have also been working with Representative Stark on this issue. I would like to know if you all support these ideas, or if you are looking at ideas similar to what Florida has done in any other cases coming up this next year?

Ms. ARONOVITZ. In the Medicaid Program we have found that Florida is very progressive in trying to curb a lot of the fraud and abuse in Medicaid. And I think a lot of the principles and a lot of the initiatives that have occurred in Florida in those areas are very responsive to some of the problems we find in Medicare.

For instance, a few years ago we looked at the problem of pill mills. And in Florida there were a lot of problems with pharmacists——

Ms. THURMAN. Right.

Ms. ARONOVITZ [continuing]. Distributing pills and whatever. And Florida was very progressive in its initiatives to develop a strike force, and also to put in a lot of controls in that program. It's those kinds of initiatives that HCFA needs to think about in its Medicare Program.

And again, the way that program is managed through the contractors, and the way that contractors are reimbursed for their efforts to curb fraud and abuse, is very different. So the principles themselves are very, very coherent and very important for us to consider in Medicare, and I think some of those are now being addressed at the Federal level.

Ms. THURMAN. Are you familiar with Operation Restore Trust?

Ms. ARONOVITZ. Yes, I am.

Ms. THURMAN. Could you give this Subcommittee an idea of the program? Because as we go forward in looking at fraud and abuse, you may be able to give some examples of what happened in Flor-

ida. Also, would you recommend this to be something that we could extend over the rest of the country?

Ms. ARONOVITZ. Yes. There was a lot of discussion, a lot of concern, about fraud and abuse in the Medicare Program, especially in some of the high-growth type benefits. That was durable medical equipment, home health, and also some of the concerns about the skilled nursing facilities.

Congress established a 2-year demonstration program that really coordinated the efforts of three HHS agencies. That was HCFA, the OIG, and the Administration on Aging, that has a very good local beneficiary network; also, the Department of Justice and various State and local agencies. They combined and coordinated their efforts and resources.

They spent about $4 million in training and travel, which is very insignificant compared to some of the benefits they received. And they focused on five States that accounted for about one-third of all Medicare beneficiaries. And that was Florida, California, Illinois, New York, and Texas.

And their focus was on those three areas that I told you about, and they really gave it a full-court press. They used a lot of the OIG resources, and they coordinated very heavily on a lot of the tools that the local law enforcement agencies had, in addition to the Department of Justice.

And they have some very impressive findings.

Now, the demonstration project is supposed to end—the 2-year demonstration will be completed in May of this year. And then they will come out with final numbers on their accomplishments, which are very impressive. I believe in the first year they reported that they recovered $42 million, and they just had very impressive type accomplishments and convictions and recoveries in some other areas, and exclusions from the program.

But probably the most important lesson that was learned and that will carryover in terms of the way these law enforcement agencies work is that they learned to coordinate their efforts and really work together to try to fight some of these problems, which is exactly what you are talking about in Florida.

So I think this has been a very, very positive program, and one where the lessons will be picked up and learned around the country and expanded.

Ms. THURMAN. Thank you. Ms. Willis, let me just ask one very quick question of you, if it is OK with the Chairman, here.

Mr. HULSHOF. Sure.

Ms. THURMAN. You and I have talked, and I know that there is a lot of conversation regarding improvements and results from IRS. Will these results be immediately noticed, or would they occur over a year, or is it something that is going to take a little bit longer?

I do not want the expectations from this hearing to be that everything that we put into change can happen and it can happen on July 15, 1998. Are these improvements going to take a while?

Ms. WILLIS. This is a long-term commitment. There are things that IRS has done and can continue to do to improve its programs and to improve the quality of service that it provides to taxpayers. But to truly modernize its processes and systems and address the high-risk problems that we have discussed is going to take a long-

term commitment on the part of IRS, on the part of the Congress, on the part of GAO and others who provide oversight.

As we move into the next millennium, and as we address the year 2000 problems, it is going to take a diversified approach where we look at not only the business requirements of how we want to run the Nation's tax system, but also a highly technical approach in terms of what opportunities technology will provide us that we can deliver to the taxpayer better services.

But there is no question in our mind that this is going to be a multiyear process that is going to have to proceed incrementally as IRS develops the capability to deliver the systems, to reengineer its process, and to improve its services.

Mr. DODARO. I think, just to add on to that, a couple of thoughts. One, I think we got into this dilemma because of overpromising and not being able to deliver. And it is not just limited to IRS. It has happened to many other agencies, as well. To rectify that we need to make the investments in the basic management foundation, technical foundation, that needs to be in place.

Third, I would think that Congress needs to settle on a credible plan, an achievable plan, and then monitor progress incrementally. And that is the way to ensure lasting change and meaningful improvements, and particularly when we are talking about an organization as large as the IRS.

And that is why I was emphasizing those management tools today, of performance measurement. And Congressman Tanner has mentioned that several times. I think that is very important. But having a credible plan is important, too. I think there has been a tendency to think that technology and throwing money at it is immediately going to solve the problems, and that is not really the case. And you need to have better management, because a lot of the problems are not technology problems, as much as they are management problems.

Ms. THURMAN. Thank you.

Mr. HULSHOF. Let me follow up briefly with just a couple of questions, Ms. Ross, and I do not intend to replow old ground. But regarding the statements made by Mr. Dodaro about money is not the only answer, in your statement you indicate that a lot of the computer matches on earned income are relatively old, or that information is not updated in a timely fashion. And you indicate that part of that is Aid to Families with Dependent Children. That is one area where SSA has really not matched data.

Have they put a plan in place so that they can match that information and update that information, so that we are not overpaying through SSA?

Ms. ROSS. They have a whole series of matches that they do. I pointed out that AFDC was one they did not do. Our concern is that, by its nature, when you take computer information from one system and then you move it on tape or disc or something to another agency, and find out how many hits you have, and then you send that information out to the field, that is just too long a process.

So computer matching was a good technology a decade ago. It is not the right technology now. And we think SSA does not have an adequate plan for the new technology.

Mr. HULSHOF. Would that also be your testimony or opinion regarding their plan where, as was reported, we had prisoners in various institutions who were actually receiving some $5 million in SSI benefits?

The Social Security Administration told you, at least through your statement, that it has begun a program to identify SSI recipients in jails who should no longer be receiving benefits. Have they made a significant effort in that regard, Ms. Ross?

Ms. ROSS. In that regard, I think they have. I think, though, we need to follow through and see if month after month that kind of information continues to flow to SSA.

Mr. HULSHOF. One final couple of questions. And I am sorry that I did not provide a copy for you. This is the latest Social Security Administration publication, that's dated May 1996, regarding disability based on drug addiction or alcoholism, which interestingly—or some would say ironically—is also printed in Spanish on the reverse side.

But it talks about, under the new law, if you are currently receiving disability benefits based on drug addiction and/or alcoholism, your cash benefits will cease January 1, 1997, which was the new law. However, the publication goes on to say that even if you stop using drugs or alcohol and still think that you could qualify through some other disability, you may reapply; and second, that you can appeal the decision that your disability is based on drug addiction or alcoholism, and benefits would continue to be paid out to a representative payee.

Now, with that publication and that advice being given out to recipients, coupled with your statement that the Social Security Administration's lengthy and complicated disability decisionmaking process results in untimely and inconsistent decisions, putting those together—and Mr. Dodaro, I am not here to create some pie in the sky—but is there any optimism that I can tell my folks back in the Ninth District of Missouri that at some point in time we are no longer going to be paying SSI to those who do not qualify, specifically those who have traditionally come under the disability of alcoholism or drug addiction? Is that anywhere on the near horizon?

Ms. ROSS. Well, with the passage of the law last year, all people who were receiving benefits based on drug addiction or alcoholism as their primary disability had to come in and be reviewed. But from the very beginning, SSA estimated that about 80 percent of those people would be returned to the rolls with a different disability. So you can view that however you would like. Twenty percent of the people are off the rolls. Eighty percent, or thereabouts, have probably come back on with another disability.

There were some people who did not come and reapply. I do not have those numbers available. But one of the things we are concerned about—and actually, SSA was, as well—is that because people are now coming with impairments that are not related to substance abuse, they are not required to have representative payees anymore. So one of the safeguards that was there is no longer in place. And I think at some point we will need to go back and see what happened to people who were formerly abusers who are now

back on the program. Do they have representative payees? Because they ought to.

Mr. HULSHOF. Mr. Dodaro, Ms. Willis, Ms. Ross, Ms. Aronovitz, thank you very much for your patience, for your time, for your testimony. You are excused, with the thanks of the Chair.

Mr. DODARO. Thank you very much.

Mr. HULSHOF. Let us continue this hearing, and call the next panel of witnesses, if we could. This hearing will continue. We are pleased to welcome Hon. Valerie Lau, the Inspector General, the U.S. Department of the Treasury. Welcome.

We also welcome Patricia Dalton, the Deputy Inspector General from the U.S. Department of Labor; and also, Michael Mangano, Principal Deputy Inspector General from the U.S. Department of Health and Human Services.

Thank you each for appearing here today, and for your patience for us finally getting to your testimony. With that, we will go to your testimony, your statements. The Chair recognizes Ms. Lau.

STATEMENT OF HON. VALERIE LAU, INSPECTOR GENERAL, U.S. DEPARTMENT OF THE TREASURY; ACCOMPANIED BY GARY BELL, CHIEF INSPECTOR

Ms. LAU. Thank you, sir. Mr. Chairman and Members of the Subcommittee, today I would like to direct my remarks to two areas. First, I will discuss the IG Act Amendments, which created my office and defined the relationship with the IRS Inspection Service. Second, I will highlight the work of our two offices in two of the high-risk areas identified by GAO. I have prepared a longer statement, which I would like to submit for the record.

Mr. HULSHOF. That will be allowed.

Ms. LAU. Thank you. As you know, the Treasury Office of Inspector General was established by the 1988 Amendments to the IG Act. Unlike most other OIGs, the amendments did not create a single audit and investigative entity for the Treasury Department. Instead, the IRS retained its own internal audit and investigative staff under the direction of the Chief Inspector.

That office has primary responsibility for all direct audit activity at the IRS. My office has oversight responsibility for the Chief Inspector's Office. The amendments also gave my office the authority to initiate, conduct, and supervise audits of the IRS. However, our capability to do many such audits is limited.

The OIG has an audit staff of approximately 160 auditors that must provide audit coverage for the remaining 11 Treasury bureaus. In contrast, the Chief Inspector has approximately 460 auditors who focus solely on IRS programs and operations. Consequently, my office must rely on IRS internal audit for most of the audit coverage given to IRS. The Chief Inspector, Gary Bell, is here with me today.

Let me now turn to a brief discussion of our work in the following areas: Financial management at the Customs Service and IRS, and oversight over IRS' tax systems modernization efforts.

Three years ago, the OIG assumed responsibility for auditing Customs' financial statements from GAO. Customs has improved its financial management; however, much needs to be done. Our audit of Customs' fiscal year 1996 financial statement indicates

tangible progress in addressing previously reported material weaknesses. While they have been addressed, they have not been fully eliminated.

We believe that Customs' planned improvement efforts are appropriately focused on control weaknesses involving invalid drawback payments, in-bond shipments, and core financial systems. Let me share just one example. Drawback payments are refunds of duties and taxes paid on imported goods that are subsequently exported or destroyed. In its effort to prevent duplicative, erroneous, or otherwise invalid drawback payments, Customs has continued to implement and to refine several compensating controls. Previously, Customs could not easily match a drawback claim to its related entry to ensure the claim was not excessive or duplicative. Beginning in 1995, Customs started linking drawback claims to their related entries.

Also, we have been working with Customs to implement a statistically valid sampling methodology to identify the extent of excessive drawback payments and determine the related loss.

IRS' fiscal year 1996 financial statements are the fifth set prepared by the IRS' Chief Financial Officer and submitted for audit by the GAO. These statements are presented in two separate sections. The first, their administrative statements, account for IRS' use of appropriated funds it receives to conduct operations. The second, their custodial statements, reflect the collection of revenue on behalf of the Federal Government.

The Inspector General and the Treasury Chief Financial Officer are closely monitoring the progress of this audit because the IRS audit results are material to the first departmentwide audited financial statements, which will be issued later this spring. Next year, the OIG will audit the fiscal year 1997 IRS administrative financial statements, and GAO will continue to audit IRS' custodial financial statements.

Now, turning to the area of tax systems modernization, many congressional committees, including this one, have already heard of the problems with TSM and are probably not interested in hearing them in detail yet again. The IRS Chief Inspector's work regarding TSM has been extensive, and we have reported those results in our semiannual report to Congress.

The Department and IRS have adopted a new approach to provide better oversight for TSM: The Modernization Management Board, or MMB. In addition, the IRS has created an Investment Review Board, or IRB, consistent with GAO's best practices self-assessment guidelines.

We believe that the MMB and the IRB are promising oversight mechanisms to help IRS address and resolve its difficult issues. While these oversight mechanisms are new, they are having an impact. For example, in the 1996 audit of TSM, the Chief Inspector found that IRS' development of the document processing system, or DPS, continued to be at risk. The auditors recommended that IRS consider canceling the DPS project. Based on this and other ongoing evaluations, the IRB recommended, and the MMB agreed, to cancel the project. DPS was terminated in October 1996.

In closing, progress has been made, but more remains to be done. We in the audit community are committed to helping management find solutions to the problems we identify.

This concludes my statement. I will be happy to answer any questions you might have. Thank you.

[The prepared statement follows:]

Statement of the Honorable Valerie Lau, Inspector General, U.S. Department of the Treasury

Madam Chairwoman and Members of the Committee:

Today, I would like to direct my remarks to two areas. First, I will discuss the role of my office under the IG Act and our relationship to the IRS Inspection Service. Second, I will describe the work of the Treasury OIG and the IRS Inspection Service in the areas defined by GAO as high risk.

ROLE OF MY OFFICE UNDER THE IG ACT

As you know, the Treasury Office of Inspector General was established by the 1988 Amendments to the IG Act of 1978. Like all other OIGs, our mission is to conduct independent and objective audits and investigations relating to the programs and operations of our Department; make recommendations that promote economy, efficiency and effectiveness; and prevent and detect fraud and abuse.

Unlike most other OIGs, however, the Amendments did not create a single audit and investigative entity for the Treasury Department. We have direct review authority over some Treasury bureaus and oversight authority over others. We oversee investigative units within four law enforcement bureaus. Also, with respect to the Internal Revenue Service, we oversee internal audit and investigative staff who have remained under the direction of the IRS Chief Inspector. That office retained primary responsibility for all direct audit activity at the IRS, while my office was assigned oversight responsibility. For remaining Treasury bureaus, we have direct audit and investigative authority.

The Amendments also gave my office the authority to initiate, conduct and/or supervise audits of the IRS. However, our capability to do many such audits is limited. We have an audit staff of approximately 160 auditors who must provide primary audit coverage for the remaining 11 Treasury bureaus. Our recent efforts have been focused on helping these other bureaus improve operations and meet the Chief Financial Officer's Act (CFO) and Government Management Reform Act (GMRA) requirements. In contrast, the Chief Inspector has approximately 460 auditors who focus solely on IRS programs and operations. Consequently, my office must rely on IRS Internal Audit for most of the audit coverage given to IRS. In addition, as you have heard today, the GAO performs an extensive amount of audit work at the IRS, including the bulk of the financial statement work.

Prior to the Amendments, the Inspection Service reported solely to the IRS Commissioner and had little contact with Treasury officials and Congress. The Amendments changed this relationship. They required that the Inspection Service's work become subject to the reporting requirements of Section 5 of the Act. As such, the Inspection Service's results are routinely included in my Semiannual Report to the Congress, including its tax writing and general government oversight subcommittees.

In keeping with this requirement, my Semiannual Reports have highlighted the work of my office and the Inspection Service in each of the high risk areas since 1990. While the IRS and Customs have made progress in managing the risks associated with each area, significant long-term concerns still remain. For this reason, both the Inspection Service and my staff will continue to focus significant audit coverage on these areas and will routinely report the results of our assessments to the Secretary, the Congress, and the public.

A clearer understanding of the scope of the Inspection Service's activities can be seen within the framework of the overall mission of the IRS. As you know, the IRS is a large, complex and geographically dispersed organization which employs over 100,000 people who collect over $1.4 trillion in tax revenues and enforce the tax laws. Considering the significant amount of money involved, the discretionary authority of enforcement personnel, the size of the organization, the massive processing operations, and the scope of taxpayer contacts taking place daily throughout the country, it is easy to see the inherent risks associated with IRS operations. Within this framework, the Inspection Service has historically directed its audit coverage to those IRS activities that are related to the collection of tax revenues, enforcement of tax laws, and processing of returns and other information.

MANAGING HIGH RISK

We are here today to talk about high-risk issues. Managing risk and minimizing the vulnerabilities is a job for all of us in the public service. IGs, department and agency managers at all levels, and the Congress share this responsibility. Congress is doing its share as evidenced by a recent series of enacted legislation. Legislation like the Government Performance and Results Act of 1993 (GPRA), Government Management Reform Act of 1994 (GMRA), and the Information Technology Management Reform Act of 1996 (ITMRA) provide a perspective and approach to improving government operations which appear well-suited to fixing the problems. These laws provide the framework for systematic long-term solutions for making a government that works better and costs less.

GAO has discussed with you their extensive work in the IRS and in other high-risk areas. Let me briefly discuss with you some of the work that my office and the Chief Inspector are doing to address those areas for which the Treasury is responsible. Let me first discuss how we are helping to address high-risk areas.

Integrate High-Risks Areas in Audit Planning—Effective audit planning focuses on high-risks areas. We have instituted a long and short-range planning system that systematically identifies programs and activities subject to the risk of fraud, waste, and mismanagement. As these areas are defined, we plan audits, evaluations, and investigations to identify management actions needed to avoid mistakes.

Ensuring That Recommendations for Corrective Action Are Implemented—Monitoring the department's implementation of recommendations is another way to ensure that progress is being made. Treasury management is ultimately responsible for implementing audit recommendations and achieving the cost benefits outlined in our reports. We monitor management's implementation through the Department's Audit Tracking System. This system allows us to follow up on management actions. For the Treasury high-risk issues, we and the Chief Inspector are making a concerted effort to examine completed corrective actions in order to ensure that they are actually having an effect on previously noted deficiencies. Additionally, my office is completing an evaluation of the Department's audit tracking system. We will make recommendations to ensure that this system provides information needed by management to assure that corrective actions are being timely and correctly made.

I will now discuss the work of my office and the Chief Inspector's as they pertain to the following: Financial management at the Customs Service and IRS; Oversight of IRS' Tax Systems Modernization efforts; Filing fraud: Asset forfeiture; Information security; and the Year 2000 problem.

Customs Financial Management—Financial management at both the Customs Service and the Internal Revenue Service has been previously reported as a material weakness and has received extensive criticism from GAO. With the advent of the Chief Financial Officers Act, these weaknesses took on greater emphasis.

To provide some perspective, the Customs Service, which is of the size and complexity of a large Fortune 500 company, has existed for well over 200 years without the discipline of undergoing annual financial statement audits. Furthermore, like most federal entities, its operational and administrative functions were organized to address budgetary needs and requirements. Therefore, it was not surprising that its systems and operations were not readily able to withstand the scrutiny of a financial statement audit.

Three years ago, we assumed responsibility for auditing Customs' financial statements from GAO. Customs has improved its financial management; however, more needs to be done. The results of Customs' fiscal year 1996 financial statement audit are a meaningful indication of the tangible progress it has made in addressing previously reported material weaknesses. While Customs' most serious material weaknesses have been addressed, they have not been fully eliminated. We believe that Customs' planned improvement efforts are appropriately focused on control weaknesses involving invalid drawback payments, in-bond shipments, and core financial systems. Customs needs to focus its energies on these efforts.

We believe the relative risk associated with Customs' financial management can be reduced with the continuing support of Customs senior and mid-level management. They must ensure that planned improvement efforts are properly implemented so that existing material weaknesses are resolved and related problems do not recur.

IRS Financial Management—IRS' FY 1996 financial statements are the fifth set prepared by the IRS' Chief Financial Officer and submitted for audit in accordance with the CFO Act. These statements are presented in two separate sections. The first section presents the financial statements of the "Administrative" operations, i.e. IRS' accounting for the appropriated funds it receives to conduct operations. The

second section presents the financial statements of the "Custodial" operations, i.e. collection of revenue on behalf of the Federal government.

Since 1992, a GAO team, which included auditors detailed from IRS' Office of the Chief Inspector, has attempted to audit IRS' financial statements. They were unable to render an opinion as to the fair presentation of these statements citing severe financial management and control problems at IRS. GAO is now auditing IRS' FY 1996 financial statements. The OIG and Treasury CFO are closely monitoring the progress of this audit because of the significance of the IRS audit results to the first ever audited Treasury-wide financial statements for FY 1996. Next year, the OIG will have responsibility for auditing the FY 1997 financial statement section pertaining to IRS' "Administrative" operations. GAO will continue to audit IRS' financial statements covering "Custodial" operations.

Tax Systems Modernization—The IRS has spent billions on TSM and there has been dissatisfaction with the results to date. IRS performed this work without having an overall plan, a consistent approach to managing contractors, or persons with the necessary skills to successfully complete the job. However, many congressional committees, including this one, have already heard of the problems with TSM and are probably not interested in hearing them in detail again.

The IRS' Chief Inspector's work regarding TSM has been extensive. Since 1991, IRS Inspection has issued almost 90 reports on TSM. These reports have reflected the same kinds of problems that GAO has reported in their audits. In our Semiannual Reports to Congress, we have highlighted the Chief Inspector's TSM work and since 1992 have reported TSM first as a major area of concern and later as a material weakness. In early 1996, we issued our own report on Treasury's Oversight of TSM which concluded that Treasury's past oversight of the modernization program had not been effective. Around the same time, the Department and IRS adopted a new approach to oversee TSM the Modernization Management Board (MMB). In addition, the IRS created an Investment Review Board (IRB) consistent with GAO's best practices self-assessment. As IRS and the Department embark on a whole new approach to TSM, the Chief Inspector continues to conduct a substantial body of audit work. In conjunction with his efforts, we plan to initiate a followup audit to assess whether Treasury has improved its ability to oversee TSM and whether IRS is addressing the recommendations made by the Chief Inspector and GAO.

I believe the Treasury OIG has a significant role to play as TSM and other "fixes" are put into place. While others continue to extensively audit the development of TSM and other IRS activities, the OIG's oversight role includes monitoring the IRS' progress in implementing previous recommendations and assuring performance of adequate audit followup. We also participate as an advisory member of the MMB. We believe that the MMB and IRB are promising oversight mechanisms to help IRS address and resolve its difficult issues.

While these oversight mechanisms are very new, they are having an impact. For example, in a 1996 audit of TSM, the Chief Inspector found that IRS' Document Processing System (DPS), an integral part of TSM, continued to be at risk because of repeated setbacks in the delivery of major DPS sub-systems. Furthermore, those setbacks indicated that IRS may not have the required technical expertise to deliver those sub-systems. The auditors recommended that IRS consider canceling any further development of DPS. Based on this and other ongoing evaluations of DPS, the IRB recommended, and the MMB agreed, that completing DPS was not cost effective given its projected return on investment. DPS was terminated in October 1996.

Filing Fraud—As with Tax Systems Modernization, the Chief Inspector's Office has established an aggressive revenue protection audit strategy. This is designed to assist IRS management in improving systems for detecting return filing fraud in advance of issuing tax refunds. In a report released last month, the IRS internal audit staff concluded that IRS' 1996 Revenue Protection Strategy initiative effectively enhanced the selection of returns most susceptible to noncompliance with filing requirements. Since Fiscal Year 1995, IRS internal audit has issued 18 reports on revenue protection activities. Some of the recommendations from those reports include methods to identify suspect tax return preparers who deliberately understate their client's tax liabilities and strategies developed to detect the use of duplicate social security numbers to claim additional tax exemptions. Other reviews addressed the suitability of electronic return originators and the prevalence of tax refund fraud related to false claims under the earned income credit program. In addition to these specific audits performed on filing fraud areas, the Chief Inspector's internal audit staff monitors the processing activities in an on-line environment each tax filing season.

Asset Forfeiture—GAO has two concerns regarding asset forfeiture vulnerabilities—the need for better accountability and stewardship of seized prop-

erty, and economies that could be realized through consolidation of the Justice and Treasury asset management and disposition functions. With regard to the management of seized property, Customs, as the custodial agent, has taken substantial actions that, if properly implemented, should remove Customs' seized-property management from the high-risk category. Customs continues to upgrade existing security at its storage facilities, appropriately focusing on those facilities where particularly large amounts of illegal drugs are stored prior to destruction. Additionally, while Customs' Fiscal Year 1995 year end physical inventory of illegal drugs and other contraband revealed significant errors in recorded quantities and quantities on-hand, its Fiscal Year 1996 year end inventory showed that these conditions had considerably improved.

Customs also is taking steps to correct previously reported weaknesses in its seized property tracking system. It is implementing a new seized asset case tracking system that, when fully operational, should offer improved controls and audit trails over seized and forfeited property, thus, reducing the ability to disguise a loss or theft of seized property. Customs is taking steps to ensure that existing weaknesses are resolved and related problems do not recur. The relative risk associated with Customs' seized property management system can be reduced with the continuing support of Customs top and mid-level management by ensuring that planned improvement efforts are properly implemented.

Since the OIG has not examined the benefits of consolidating the Justice and Treasury funds, we are unable to comment on the extent of GAO's estimated savings. Our work has focused on the use of Treasury Forfeiture Funds by state and local law enforcement recipients. Our conclusions from this work raises concerns regarding the administrative difficulty imposed on recipients because of the existence of two sets of guidelines to which they must adhere. We also had some difficulty in assessing whether Treasury funds have been spent in accordance with Treasury program criteria. We found that recipients commingle funds from Treasury, Justice, and other sources making it more difficult to ensure that the funds were being used for intended law enforcement purposes. Therefore, because of the different spending guidelines and program requirements, local law enforcement agencies would likely find it easier to receive money from one fund or to comply with one uniform set of guidelines for both funds. Treasury and Justice have been working together to establish more uniform guidelines.

Information Security—GAO is rightly concerned about malicious attacks on computer systems. Federal computer systems are open to attack because so many computers are interconnected these days. The Government is vulnerable, and so is the Treasury Department. Computer intruders, whether outside or inside our bureaus, look to defraud and steal government resources, access sensitive data, and disrupt government services and operations. Whatever the nature of the attack or its consequences, the seriousness of this threat is real.

At Treasury OIG, we have a new group that specializes in information technology issues. So far, we have reviewed information security policies for Customs and ATF. We have reviewed information security administration, program change procedures and mainframe security software at Customs, ATF and Secret Service during our annual financial audits. These audits identify a number of weaknesses that intruders could exploit. Some reported weaknesses have been corrected; however, others have not. We have also issued a comprehensive report on disaster recovery planning that compares the plans among the different Treasury bureaus. We found several bureaus do not have a workable disaster recovery plan—a serious security weakness. IRS Inspection Service auditors have also given extensive coverage to computer security issues. For example, in 1992, the Inspection Service reported that the Integrated Data Retrieval System (IDRS) control systems did not detect or prevent unauthorized accesses by IRS employees to tax information. The information obtained was used for improper and illegal purposes.

In response to the 1992 report, IRS management implemented the Electronic Audit Research Log (EARL) system to identify employees who improperly access IDRS. Since EARL development began in 1993, Inspection Service auditors have monitored and reported on the design and progress of the system deployment. In addition, my office performed a followup audit to evaluate IRS' progress in correcting the IDRS access weaknesses. IRS managers have used these assessments to set the strategic direction for EARL and develop operating procedures to improve their overall effectiveness in identifying unauthorized access to IDRS.

Even though improvements have been made to detect and deter unauthorized or improper access to tax information, weaknesses still exist. For example, IRS management still has not completed an important corrective action of obtaining security accreditation for the EARL system. In 1994, the Chief Inspector's office also identified significant security weaknesses over sensitive taxpayer information on personal

computers and mini-computer systems in IRS. They made a number of recommendations to strengthen controls, however, in a 1996 followup audit, they found that these weaknesses still exist. Clearly, more needs to be done to improve information security at IRS.

Year 2000 Problem—As we have already heard, agencies must immediately assess their Year 2000 risk exposure and need to budget and plan how they will overcome the date problem for all of their mission critical systems. These plans and strategies need to be developed immediately if conversion is to be accomplished by early 1999. The Department's schedule and milestone dates are in accordance with the Government-wide schedule, with most of the conversion work expected to be completed by early 1999. While the Department's approach is consistent with GAO's recommendations, the ultimate challenge for Treasury will be to ensure that its approach is appropriately applied in an expeditious and timely manner.

The Department is currently finalizing their Year 2000 approach and vulnerability assessment. We know that Year 2000 is a particularly high risk area at IRS, Customs, and the Financial Management Service, and the assessment may identify other information systems which may be affected by the Year 2000 problem. Our strategy has been to await the results of the vulnerability assessment, and then determine where direct OIG involvement is required. At that time, we intend to identify issues, programs, or systems that might cause completion dates to slip or milestones to be missed. Furthermore, we are meeting with Department and bureau information resources management officials. We regularly attend the Treasury Year 2000 work group meetings and participate in the Chief Information Officers and Chief Financial Officers Councils where the Year 2000 problem is a regular agenda item. Additionally, we are conducting a Department-wide Survey of Information Technology investment management practices. As a part of this survey, we are assessing the impact of the Year 2000 problem on systems development initiatives and plan to follow their progression.

To conclude, I believe the federal audit community is an important element in the identification, analysis, and removal of high-risk areas. Our collective work can provide assistance to management in its efforts to minimize high-risk programs and other vulnerable areas. Audit followup is also a critical part of the puzzle and should be used to report on progress and identify what is working and what is not. I believe that my office, together with the Chief Inspector's Office, has a good record in this effort.

This concludes my statement. I will be happy to answer any questions you or members of the committee may have.

Chairman JOHNSON. Thank you very much.

Ms. Dalton.

STATEMENT OF PATRICIA A. DALTON, DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF LABOR

Ms. DALTON. Good afternoon, Madam Chairman, and Members of the Subcommittee. Thank you for inviting the Office of Inspector General to discuss pension enforcement activities of the Department of Labor. I am here in my capacity as Deputy Inspector General to present the views of the OIG, which may not necessarily be representative of those of the Department.

It is the opinion of OIG, Madam Chairman, that ensuring that pension assets are safeguarded is an area that continues to require major departmental and congressional attention. Current pension plan assets now total close to $3.5 trillion. Because of the nature of these assets—large sums of money that are invested for deposit for a future benefit—the potential for serious abuse exists, and no one is really exempt from becoming a victim of this abuse. Our criminal investigations demonstrate that people being defrauded come from all walks of life. It does not matter whether you are a truckdriver, or a roofer, or even a Member of Congress.

The Department must be effective in ensuring that pension funds are deposited fully and promptly to workers' accounts, and that these funds be safe while held in trust. The problem of pension asset fraud and abuse is of such importance that the Department of Justice recently launched an initiative to increase prosecution of pension-related cases.

A serious problem that has been identified in the pension area is that of ensuring that contributions withheld from employee paychecks are appropriately and promptly deposited by employers. Recently implemented regulations by the Department reduce the time in which someone could temporarily use the pension funds inappropriately and then deposit the funds without being detected. However, those regulations will not prevent individuals inclined to do so from converting funds for their own use. In fact, the government continues to identify instances of employee pension contributions not being deposited properly, or funds diverted for the personal use of those administering the assets. The OIG is of the opinion that enforcement and oversight of this area needs to remain a priority of the Department of Labor.

Last week, my office issued an audit of the Department's employee contribution project which was initiated by the Department's Pension and Welfare Benefits Administration, in May 1995. This project was initiated to address the issue of plan administrators' failure to remit employee contributions to 401(k) pension plans and health plans.

Our audit found that PWBA's efforts in this project had a positive impact on protecting plan assets, particularly with respect to increased enforcement in this area, as well as participant awareness of the problem. However, we also found that improvements were needed in the targeting as well as in the case management information system used by the Pension and Welfare Benefits Administration for this enforcement initiative.

The OIG also has some longstanding concerns with respect to ensuring that funds are safeguarded while they are held in trust by plan administrators, service providers, or trustees. Chief among our recommendations in this area is the need to repeal the limited-scope audit provision of ERISA. These provisions result in inadequate auditing of pension plan assets.

According to PWBA, more than $950 billion in pension plan assets, out of approximately $2 trillion subject to the audit requirements of ERISA, are not examined because of the limited-scope audit provision. Madam Chair, the OIG believes that requiring full-scope audits of all employee benefit plans is a reasonable mandate that would not place an undue burden on business. After all, at least half of the Nation's pension plan assets are currently the subject of full-scope audits. To illustrate the difference in value between a limited-scope audit and a full-scope audit, I have attached to my written testimony a copy of the audit opinions from each type of audit.

The OIG believes that failure to adequately audit pension plans opens the doors to many forms of fraud and abuse, including understating required contributions or degrees of risk and overstating plan investments and valuations. Obviously, these factors can lead to pension plan failures.

The OIG has also recommended that independent public accountants and plan administrators be required to report serious ERISA violations directly to the Department, in order to enhance oversight of pension plan assets, as well as to ensure the timely reporting of violations. Legislation to address these concerns has been proposed in past years, but a legislative fix has yet to be enacted. It is my understanding that the administration is currently working on introducing a proposal that would address these two OIG recommendations.

From an investigative perspective, the OIG continues to focus on identifying abuses of service providers, administrators, and others, with respect to union pension funds and investment activities. My office currently is conducting criminal investigations of more than $200 million in pension assets that are suspected of being abused or defrauded.

Our investigations continue to uncover abuses of employee benefits plans in the manner in which pension assets are managed and invested. We have found that the size of these plan assets are inviting targets to unscrupulous service providers and individuals who offer services to plan administrators, such as accountants, attorneys, or investment advisors.

Madam Chairman, it is the OIG's opinion that ensuring pension assets are safeguarded is of such importance we are devoting considerable resources to this effort.

This concludes my oral statement. I will be pleased to answer any questions.

[The prepared statement and attachments follow:]

Statement of Patricia A. Dalton, Deputy Inspector General, U.S. Department of Labor

Good Morning Madam Chair and Members of the Subcommittee. Thank you for inviting the Office of Inspector General (OIG) to discuss pension plan enforcement activities of the Department of Labor. I am here in my capacity as Deputy Inspector General to present the views of the OIG, which may not necessarily be representative of those of the Department of Labor.

It is the opinion of the OIG, Madam Chair, that ensuring that pension assets are safeguarded is an area that continues to require major departmental and congressional attention. So I thank you for your interest in holding this hearing to further explore this issue. As you may be aware, current pension plan assets now total close to $3.5 trillion. Because of the nature of these assets—large sums of dollars, entrusted for deposit and long-term investment for a future benefit—the potential for serious abuses exists. And no-one is really exempt from becoming a victim. Our criminal investigations of pension plan fraud demonstrate that the people being defrauded come from all walks of life. It does not matter whether you are a truck driver or a roofer contributing to an union pension fund or whether you are a Member of Congress.

The Department must be effective in ensuring that pension funds are deposited fully to workers' accounts in a prompt manner and that these funds be safe while held in trust. The problem of pension asset fraud and abuse is of such importance that the Department of Justice has launched an initiative to increase prosecution of pension-related cases.

JURISDICTION

By way of background, oversight responsibility over the various aspects of the Nation's pension system and assets rests with four Federal agencies: the Department of Labor's Pension and Welfare Benefits Administration (PWBA); the Internal Revenue Service (IRS); the Pension Benefit Guaranty Corporation (PBGC); and the Department of Labor, Office of Inspector General (OIG).

PWBA is responsible for administering Title I of the Employee Retirement Income Security Act 1974 (ERISA), which governs the rights and financial security of em-

ployee benefit plan participants and beneficiaries in the Nation's private pension and welfare benefit plan system. PWBA's responsibilities include the promulgation of regulations, providing interpretations of ERISA, and the enforcement of the provisions found in Title I. The IRS is responsible for the enforcement of ERISA's Title II tax-related provisions, while PBGC is responsible for Title IV, which provides Government insurance in the event of failure of certain types of pension plans. Title III of ERISA provides the framework for all of the agencies to coordinate their activities.

Under the Inspector General Act of 1978, as amended, the OIG has oversight responsibilities over PWBA's programs and operations. Over the years, the OIG has conducted audits to identify weaknesses in the system and to make recommendations to improve the oversight of the Nation's pension assets. In addition, the OIG is the investigating unit within DOL for criminal labor racketeering and organized crime matters, and thus, some of the OIG's investigative jurisdiction regarding employee benefit plans overlaps that of PWBA. Within our jurisdiction, we conduct investigations into: (1) labor-related criminal conduct involving unions and/or industries with demonstrated ties to, or influences by, known organized criminal groups, whether they be traditional organized crime groups or newer, non-traditional groups; and (2) significant, prolonged, systematic and related criminal conduct and may be categorized as labor racketeering.

ENSURING PENSION FUNDS ARE FULLY AND APPROPRIATELY DEPOSITED

A serious problem that has been identified in the pension area is that of ensuring that contributions withheld from employee paychecks are appropriately and promptly deposited by employers. The Department has taken steps to help ensure this by making regulatory changes that reduce the time from which contributions are withheld or paid by the employee and received by the employer and the time the contribution is considered a plan asset. While these regulations reduce the time in which someone could temporarily use the pension funds inappropriately and then deposit the funds without being detected, they will not prevent individuals inclined to do so from converting funds for their own use. That type of activity needs to be addressed through an aggressive criminal enforcement program. In fact, the Government continues to identify instances of employee pension contributions not being deposited properly or funds diverted for the personal use of those administering the assets. The OIG is of the opinion that enforcement and oversight of this area needs to remain a priority of the Department.

Last week, my office issued an audit of the Department's employee contribution project (ECP). This project was initiated by PWBA in May 1995 to address plan administrators' failure to remit employee contributions to 401(k) pension plans and health plans. The purpose of the OIG audit was to determine if the Department, through the ECP, is adequately addressing the area of employee contributions to ensure that funds in those plans are safeguarded from unscrupulous plan administrators.

Our audit found that PWBA's efforts in this project had a positive impact in protecting plan assets, particularly with respect to increasing enforcement in this area as well as participant awareness of the problem. The latter was evidenced by a significant increase in participant complaints to PWBA. However, we also found that improvements were needed in the targeting of this enforcement initiative as well as in their Case Management Information System. The audit found that PWBA had not focused its investigative resources on plans with the most serious potential for abuse. We attributed this ineffective targeting to the fact that PWBA left the development of enforcement strategies to the discretion of regional directors, but did not conduct a timely evaluation of project results. As a result, enforcement results varied from region to region. Strategies utilized by the regions included reviewing participant complaints, referrals, and leads from plan service providers or administrators; as well as case development through computer targeting or self initiation. It is our opinion that an evaluation of project results would assist management in identifying the most effective targeting strategies, evaluating the success of the project, and determining its future scope and direction. PWBA is now evaluating the results of the ECP project.

We also found that data in PWBA's Case Management System is inaccurate, particularly with respect to information on the sources of cases and occurrences of fiduciary violations. It is our opinion that the accuracy of this data is essential in enforcement planning and, when correlated with case results, crucial in assessing the success of the project.

We also found that PWBA does not collect data or report on funds that have been misapplied and which are unrecoverable by participants or the Federal Government.

The OIG believes that, by not providing information on unrecoverable assets, as it does for restored assets, PWBA fails to communicate a complete picture of this issue. This partial disclosure may be misleading PWBA clients as to the seriousness of this issue and deprives the Congress and the Department pertinent information.

ENSURING PENSION ASSETS ARE SAFEGUARDED WHILE IN TRUST

The OIG also has some long-standing concerns with respect to ensuring that funds are safeguarded while they are held in trust by plan administrators, service providers, or unions.

Chief among our recommendations in this area is the need to repeal the limited scope audit provision of the Employee Retirement Income Security Act (ERISA) of 1974, which results in inadequate auditing of pension plan assets. Since 1984, the OIG has reported its concerns that employee pension funds are not being adequately audited to ensure that they will be available in the future to pay promised benefits. This provision exempts from audit all pension plan funds that have been invested in institutions such as savings and loans, banks or insurance companies already regulated by Federal or State Governments. At the time ERISA was passed two decades ago, it was assumed that all of the funds invested in those regulated industries were being adequately reviewed. Unfortunately, as we have found from the savings & loan crisis, that is not always the case.

According to PWBA, more than $950 billion in pension plan assets (out of approximately $2 trillion subject to audit requirements under ERISA) are not examined because of the limited scope audit provision. Currently, because of this provision, independent public accountants (IPAs) conducting audits of pension plans cannot render an opinion on the plan's financial statements in accordance with professional auditing standards. It is important to note that the disclaimer of any opinion on the financial statements includes even those assets that are not held by financial institutions. The OIG believes that these Ano opinion@' audits provide no substantive assurance of asset integrity to benefit participants or the Department. Our concerns in this area were raised in two OIG audits and have subsequently been supported by PWBA, the General Accounting Office, and the American Institute of Certified Public Accountants.

Madam Chair, the OIG believes that requiring full scope audits of employee benefit plans is a reasonable mandate that would not be a burden on businesses. Currently, at least half of the Nation's pension plan assets are the subject of full scope audits. Moreover, these audits are usually routine add-ons to annual financial audits of a corporation, and therefore, their specific cost is not high. To illustrate the difference in value between a limited scope audit opinion and a full scope audit opinion, I have attached a copy of each to my testimony.

The OIG believes that the failure to adequately audit pension plans opens the door for many forms of fraud and abuse, including understating required contributions or degrees of risk, and overstating plan investments and valuations. Obviously, these factors can potentially lead to pension plan failures.

The OIG has also recommended that independent public accountants (IPAs) and plan administrators be required to report serious ERISA violations directly to the Department. The OIG believes this requirement will enhance oversight of pension plan assets as well as ensure the timely reporting of violations. This change will involve accountants in the kind of active role that they are supposed to play in the safeguarding of pension assets, by providing a first line of defense to plan participants through their timely and direct reporting of potential problems with employee benefit plans.

Because of the vulnerability of pension assets to fraud and mismanagement, Madam Chair, the OIG believes that full scope audits of employee benefit plans and reporting of serious ERISA violations by IPAs and plan administrators are crucial factors in ensuring that pension assets are safeguarded. However, while legislation to address these concerns has been proposed in past years, a legislative fix has yet to be enacted. It is my understanding that the Administration is currently working on introducing a proposal that would address these two OIG recommendations.

From an investigative perspective, the OIG continues to focus on identifying abuses by service providers, administrators, and others with respect to union pension funds and investment activities. The OIG is currently conducting investigations of more than $200 million in pension assets that are suspected of being abused or defrauded. Our investigations continue to uncover abuses of employee benefit plans in the manner in which pension assets are managed and invested. The size of these plan assets offer inviting targets to unscrupulous service providers and individuals who offer services to the plan administrators such as accountants, attorneys, or investment advisors.

An example of some of the types of abuses we have identified involves an attorney for an employee benefit plan with over $30 million in assets. In this case, the attorney engaged in a scheme to temporarily divert pension assets to invest in an offshore, lucrative (yet high-risk) investment scheme. Some $10 million in pension assets were lost in the scheme when the offshore investors stole the money. The attorney pled guilty to charges of conspiring to solicit and receive kickbacks related to influencing the investment of the $10 million of pension funds. Other service providers to the fund, an investment advisor and an accountant have been charged as well. The attorney is currently incarcerated.

The OIG, in conjunction with its probe of labor racketeering in the construction industry, has been looking into the use of pension plan assets as loans for construction projects and other related loan activity. These cases are very complex in terms of the way the fraud is concealed. An example of this type of activity involved a case where an individual in California pled guilty to charges that he was involved in a scheme to defraud pension funds through the use of construction loans. The defendant, acting as the general managing partner of a partnership, obtained over $10 million in construction financing through a mortgage company from four union pension funds. As part of the loan agreement, the defendant was advanced funds in order to directly pay subcontractors for any work that they performed on the project. To obtain a release for some of the funds, the defendant was obligated to provide the mortgage company with documentation supporting the use of the funds to pay the subcontractors for construction materials and services. The defendant used the money on other unrelated real estate construction projects, while the project that was to be funded with the money failed. Unfortunately, the pension plans had to absorb the monetary loss.

The OIG is also playing a very active role in the Attorney General's Pension Abuse Initiative. This enforcement project seeks to increase emphasis on the problem of pension asset fraud and abuse. U.S. Attorneys' offices are working with Federal and State Government agencies to determine the magnitude of this problem in their respective districts. Of the initial cases that have been identified where prosecution is anticipated, at least 20 percent are being investigated by this OIG. The cases, which are scattered across 36 different federal districts, involve embezzlements and kickbacks to union and plan officials ranging from $3,000 to $28 million.

CONTINUING OIG OVERSIGHT

Ensuring that pension assets are safeguarded is of such importance that the OIG has prepared a 5-year audit plan of potential areas we will be exploring with respect to pensions. As part of this endeavor, in this next year, we will be conducting an audit on ERISA reporting and disclosure requirements. ERISA requires a significant amount of reporting and disclosure by employee benefit plans as a means of protection for employee benefit plan participants. Our review will determine how the IRS and PWBA gather the required information, and analyze how the information is used by the Government and participants. Since reporting and disclosure requirements place a burden on plan administrators yet are critical to participant protection, we will attempt to determine if the current requirements are necessary and sufficient to accomplish the intent of ERISA.

The OIG will also evaluate PWBA's enforcement strategy with respect to ERISA's prohibited transaction rules, fiduciary responsibilities, and reporting and disclosure requirements. We will specifically evaluate the use of computer targeting as an enforcement tool and the resources devoted to it and will obtain information from other agencies to determine any other targeting methodologies of benefit to PWBA.

The OIG will also monitor the development of PWBA's two major computer system development projects—their new form 5500 system and a new Case Management System from their start through completion. At a 5-year projected cost of $59 million for the form 5500 system alone, OIG monitoring is necessary to ensure that the systems are an appropriate and efficient tool in PWBA's oversight and enforcement efforts.

Madam Chair, this concludes my prepared statement, I would be pleased to answer any questions that you or the other Subcommittee Members may have.

FULL SCOPE AUDIT OPINION

Report of Independent Accountants

April 4, 1994

To the Savings and Investment Plan
Committee and the Participants of the

In our opinion, the financial statements and related schedules listed in the index appearing on page 1 of this Annual Report present fairly in all material respects, the net assets of the Employees Savings and Investment Plan at December 30, 1993 and 1992, and the changes in its net assets for each of the three years in the period ended December 30 1993 in conformity with general accepted accounting principles. These financial statements are the responsibility of the Plan Administrator; our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with generally accepted auditing standards which require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by the Plan Administrator, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for the opinion expressed above.

Our audits were made for the purpose of forming an opinion on the basic financial statements and related schedules taken as a whole. The additional information included in Exhibits I, II and III is presented for purposes of additional analysis and is not a required part of the basic financial statements but is additional information required by ERISA. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

DISCLAIMER - NO OPINION

INDEPENDENT AUDITORS' REPORT

To the Stock Ownership Plan Committee of the
Ownership Plan:

We were engaged to audit the financial statements of the ip Plan as of December 31, 1994 and 1993, and for the years then ended and the supplemental schedules as of and for the year ended December 31, 1994. These financial statements and supplemental schedules are the responsibility of the Plan's Administrator.

As permitted by Section 2520.103-8 of the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974, the Stock Ownership Plan Committee (SOPCO) instructed us not to perform, and we did not perform, any auditing procedures with respect to the information certified by Bankers Trust Company, the Trustee of the Plan, except for comparing the information with the related information included in the financial statements and supplemental schedules. We have been informed by the SOPCO that the Trustee holds the Plan's investment assets and executes investment transactions therein. The SOPCO has obtained a certification from the Trustee as of and for the years ended December 31, 1994 and 1993, that the information provided to the SOPCO by the Trustee is complete and accurate.

Because of the significance of the information that we did not audit, we are unable to, and do not, express an opinion on the accompanying financial statements and supplemental schedules taken as a whole. The form and content of the information included in the financial statements and schedules, other than that derived from the information certified by the Trustee, have been audited by us in accordance with generally accepted auditing standards and, in our opinion, are presented in compliance with the Department of Labor's Rules and Regulations for Reporting and Disclosure under the Employee Retirement Income Security Act of 1974.

July 21, 1995

New York City
Philadelphia
Washington, D.C.

Chairman JOHNSON. Thank you very much.
Mr. Mangano.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. Thank you very much, Madam Chairman and Members of the Subcommittee. We appreciate the opportunity to be here this morning to present to you what we think are some of the more important vulnerabilities in the Medicare Program.

I would recommend for your consideration three areas, one of which was already talked about a little bit earlier this morning, home health. We would add to that list hospice and durable medical equipment.

Far and away, we believe that the home health benefit is the one that is the most vulnerable in the Medicare Program today. With expenditures increasing about fivefold over the last 6 years and the number of visits doubling over that time period, we think that the program is growing fast. And unfortunately, we think a large contributing factor to that is fraud and abuse. In 1990, the program cost $3½ billion. Last year, it was up just under $17 billion.

We have completed eight audits of home health agencies in California, Florida, and Pennsylvania, and we found error rates at those home health agencies of 19 to 64 percent. That is, we found visits that were either unreasonable or not necessary, patients who were not homebound or not properly authorized by a physician, and services that were billed but actually were not delivered. Preliminary data that we have from statewide reviews in other States bear out the same kind of seemingly similarly high error rates.

We are also concerned about the extreme variation between the numbers of visits between home health agencies, themselves. Those home health agencies we would consider the lower cost ones were averaging about 33 visits a year per patient; whereas, those at the higher end were offering over 100 visits per beneficiaries.

We have offered a number of recommendations to the Health Care Financing Administration which I want to reiterate here. They deal with more effective targeting the reviews of those home health agencies, better case management strategies, and also involving beneficiaries more into the process itself.

We think that the problems are so pervasive in the home health area that we would think that a legislative fix, in terms of restructuring the payment method, is clearly well in order at this time. Some of the options that we have offered are prospective payment, capitation payments, and benefit targeting.

In addition to issues surrounding home health, we are also very concerned about the substantial growth in the hospice benefit and the lengths of stays of persons in hospice. Our work in this area began in 1994 when we took a look at Puerto Rico and what was going on there. In Puerto Rico we found large numbers of beneficiaries who are not terminally ill receiving the hospice benefit. We had recommended recovery of almost $20 million in overpayments in that area.

We have also completed more recently 12 audits of hospice organizations in Illinois, Florida, Texas, and California. In those facilities we found an error rate of over 65 percent for those beneficiaries who were in hospice care for over 210 days. That was approximately $83 million in overpayments for beneficiaries who were

really not eligible for the service at the time they entered into it. We also found a particularly serious vulnerability of hospice beneficiaries in nursing homes, which I pointed out in my written testimony.

We think that the Congress has some opportunities here to consider at least two recommendations. One is that you reduce the Medicare payments after 210 days in a hospice. That would give the hospice some financial security that patients that live longer than initially expected would have some resources available to the hospice to take care of it, but would also make the hospice a little more careful in making eligibility determinations at the beginning.

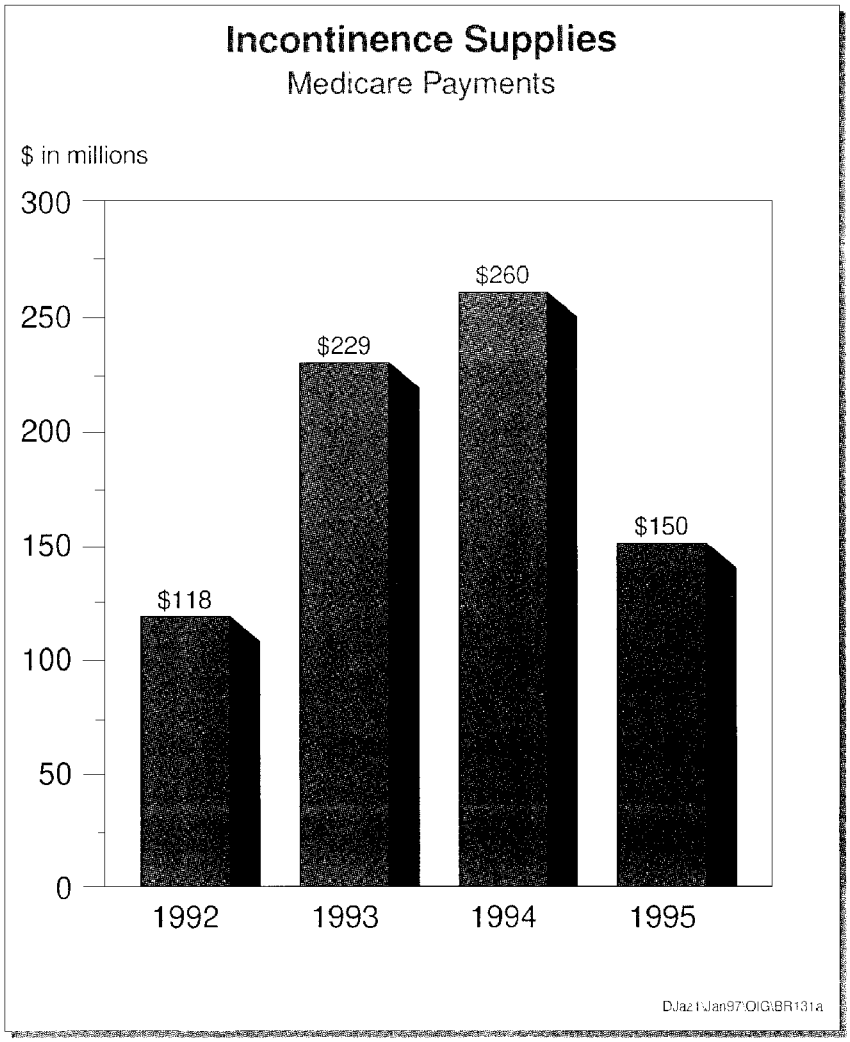
The second recommendation is to reduce the hospice payment for patients living in nursing homes to more accurately consider the kinds of services that those beneficiaries really need and the services that are already being provided by the nursing home.

The third area is, I think, a little bit more hopeful in that some things have been done already. That is in the durable medical equipment and supplies area. We would applaud what HCFA has done in narrowing down the number of carriers to four. These are the durable medical equipment regional carriers who really specialize in making payments for durable medical equipment.

We see, though, continuing problems with overutilization in areas of wound care; false billings for incontinence supplies, body jackets; and excessive payments for oxygen, enteral nutrition, and nebulizer drugs. We find this to be a particular problem in nursing homes.

The chart that I have over there gives you one example of where some administrative action can really pay some dividends. Back in 1994, we conducted a series of evaluations that pointed out that incontinence supplies were being overbilled to the Medicare Program. That is, the services that were being billed were not really the kinds of supplies that were being delivered.

[The chart follows:]



We started a nationwide investigation involving over 20 cases across the country, and the Health Care Financing Administration instructed their durable medical equipment carriers to really intensify the review. As you can see from that chart, the incontinence supplies then dropped almost $100 million in 1 year because of that threefold action. So I think some things can be done administratively.

We also think there are some legislative fixes here that are worthy of your consideration. One is to bundle up some of the costs of durable medical equipment into the nursing home facility fee; and second, to free up HCFA to be able to do more competitive bidding

for these services, so that they can get a fair market value for the kinds of products beneficiaries are receiving.

My written testimony identified a few other areas, which I will not go over now. So let me close by saying that we appreciate the opportunity to testify here this morning.

[The prepared statement follows:]

Statement of Michael F. Mangano, Principal Deputy Inspector General, U.S. Department of Health and Human Services

Good Morning, Madam Chairman. I am Michael F. Mangano, Principal Deputy Inspector General of the Department of Health and Human Services. Since 1976, the primary mission of the Office of Inspector General has been to protect and recommend improvements to the programs and management of the Department of Health and Human Services. This mission is accomplished through audits, investigations, and inspections designed to reach all organizational levels of the Department, its contractors, grantees and providers of goods and services to departmental programs.

As this Subcommittee is aware, Medicare is one of our nation's most important social programs. It provides health care coverage for more than 38 million elderly or disabled Americans. Because of the huge sums of money being spent, $191 billion in FY 1996, there will always be individuals or companies that attempt to defraud the Medicare program.

The General Accounting Office has outlined a number of vulnerable areas within the Medicare program in its latest reports entitled "High Risk Series." These include payment safeguards, claims processing, and managed care. We certainly agree that these are important and vulnerable areas. However, I would like to add to what GAO has said by bringing to your attention three programmatic areas of the Medicare program that we believe are particularly vulnerable to systemic fraud, waste, and abuse. These are home health, hospices, and durable medical equipment and supplies. We have intensified our work on these programs in the last two years.

HOME HEALTH

Medicare Part A pays for home health services for beneficiaries who are homebound, in need of care on an intermittent basis, and under the care of a physician who both establishes a plan of care and periodically reviews it. Beneficiaries receive numerous services including part-time or intermittent skilled nursing care and home health aide services, physical speech and occupational therapy, medical equipment and supplies, and medical social services. The benefit is unlimited as long as the services are considered medically necessary.

Rapid Growth.

The home health benefit is the fastest growing component of the Medicare program. In FY 1990, Medicare spent $3.5 billion for home health services for approximately two million beneficiaries. By FY 1996, expenditures had grown 5-fold to $16.9 billion, and the number of beneficiaries increased to 3.7 million. Home health expenditures now account for 8.8 percent of total Medicare spending, compared to 3.5 percent in 1990. In addition to the increasing number of home health beneficiaries, utilization has doubled, from an average of 36 visits per Medicare beneficiary receiving home health benefits in 1990 to 76 visits in 1996. The Congressional Budget Office estimates that spending for home health services will reach $31 billion by 2002.

The reasons for the rapid growth of home health expenditures are numerous. Some of the growth is appropriate and expected due to changes made to the benefit, demographic trends, and technological advances. Court cases have also liberalized coverage of the benefit so that more beneficiaries can receive care for longer periods. There are many new medical technologies, such as infusion therapies, which can now be provided at home that in past years would only have been delivered in hospitals. In addition, we know that a growing and aging Medicare population will result in increased home health costs. The trend toward providing more care in the community instead of institutions has also impacted the use of home health services. Finally, growth can be attributed to the fundamental structure of the benefit as well as problems with the management of the home health benefit.

Fraud and Abuse.

Unfortunately, fraud and abuse also significantly impact the high growth rates of home health. Over the past several years, we have issued evaluations and audits that have identified numerous types of fraud and abuse problems. The home health benefit is particularly susceptible to exploitation compared to other types of health services because the care is provided in patients' homes with limited supervision.

We have now completed audits of eight home health agencies in Florida, Pennsylvania, and California. These audits revealed that the agency error rates—the percent of the home health visits paid for by Medicare but which did not meet Medicare guidelines—varied from 19 to 64 percent. We found visits that were not considered reasonable or necessary, visits for patients who were not homebound, visits improperly or not even authorized by a physician, and visits which were not provided to Medicare beneficiaries. Preliminary data from additional audits underway in other States indicate similarly high error rates. We are therefore concerned that such high error rates may be commonplace.

Unexplained Variation.

We are also concerned about the extreme variation in payments to home health agencies and the fact that such variations are growing without clear justification. In FY 1993, lower cost home health agencies (those which provided less than the national average of visits per episode) averaged 30 visits per episode, whereas the higher cost agencies (those with visits per episode above the national average) provided 85. One year later, the lower cost agencies provided 33 visits per episode, while the average for the higher cost agencies jumped to 102. We found that private for-profit home health agencies tended to be the more costly. Additionally, we have found that home health agencies in four southeastern States—Tennessee, Alabama, Mississippi, and Georgia—averaged twice as many visits per Medicare beneficiary as home health agencies in all other States. These four States averaged approximately 100 visits per episode compared to approximately 54 for all other States.

Our analysis indicates that beneficiary age, race, gender, qualifying condition, principal diagnostic codes, and overall quality of care do not account for these variations. It appears to us that the differences are due mostly to the discretion afforded home health agencies to influence the amount of care given to their clients.

Looking for Solutions.

Our work has shown repeatedly that there is a need for greater control and protection from fraud and abuse. However, we must proceed cautiously to ensure that any measures to control the benefit do not harm those beneficiaries who truly need these services. Our focus must be on protecting the benefit as well as controlling expenditures and minimizing the potential for fraud and abuse.

To learn more about how this might be done, we examined practices of private insurance companies, State Medicaid agencies, the Department of Veterans Affairs, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and numerous health maintenance organizations (HMOs) manage their home health care programs. While their benefit structures were similar to Medicare's, they did try to control costs in ways that Medicare does not. For example, some place limits on the number of visits or caps on the dollar amount that can be paid. Many tried to target their programs more specifically to the individualized needs of their beneficiaries. They also undertook more intensive utilization control measures such as reviews of physician referral rates, post-pay edits, and utilization profiling combined with physician education.

We found that HMO's provide home health care for only one-fourth the cost of the Medicare fee-for-service program. The HMOs that responded to our survey spent an average of $882 per beneficiary in 1994 compared to Medicare's fee-for-service cost of $3,464. They do this by using case managers to review and approve patient care. These case managers work with physicians to plan care and write orders, review and approve both initial and continuing visits, review medical necessity, track and report outcomes and cost savings on a monthly basis, and participate in quality assurance activities such as clinical record reviews, team meetings, and case conferences. They carefully control both the number and kind of visits, constantly evaluating the care provided.

Administrative Remedies.

Based on these practices and on our own analysis of weaknesses which we found, we have made several recommendations aimed at controlling Medicare expenditures and reducing the potential for fraud, waste and abuse. These recommendations include more effective reviews of home health agencies, funding case management pro-

grams in the fiscal intermediaries, ensuring that fiscal intermediaries have adequate resources to detect inappropriate claims, and requiring beneficiaries to certify their "homebound" status.

Legislative Changes.

However, we believe that management actions like these will not be sufficient. The problems are so commonplace that a restructuring of Medicare's payment system is called for. Options include prospective payment, capitation of payment for services, beneficiary cost sharing, and benefit targeting.

Given the current rapid growth rate, substantial savings can be attained by preventing abuse and constraining over utilization of this benefit. The amount would, of course, depend on the success of payment control methods or the type of benefit restructuring enacted into law. Any estimate of savings is sensitive to many factors such as the actual home health growth rate, growing use of Medicare managed care and behavioral changes due to any legislative or regulatory changes. However, to give a general sense of the problem and of potential savings, a 10 percent reduction of payments last year would have saved $1.7 billion, and a 20 percent reduction would have saved $3.4 billion.

HOSPICE

The Medicare hospice benefit was established in 1983 and may be elected by Medicare beneficiaries who are diagnosed with a terminal illness and have a life expectancy of 6 months or less. Hospice is the provision of palliative care, usually in the home, where the dying person can be in contact with family and friends. Rapid Growth. Total hospice payments have increased dramatically. In 1995 Medicare paid approximately $2 billion for hospice services, more than 24 times the amount spent in 1986. In contrast, Medicare expenditures for home health services grew about 5 times during the same time period. We are concerned about the substantial growth in hospice payments and lengths of stay for patients in hospice.

General Fraud and Abuse.

We have recently undertaken a number of studies related to Medicare's hospice benefit. We found that certain providers are misusing the benefit by enrolling a high number of ineligible beneficiaries. In 1994, we completed a review of Medicare hospice eligibility in Puerto Rico. This study disclosed large numbers of beneficiaries in hospice care who were not terminally ill and therefore not eligible for the benefit. We estimate that $20 million was inappropriately paid for services rendered to ineligible patients in Puerto Rico.

With the Puerto Rico results as background, we began a broader review of this important benefit. We have also audited 12 large hospices located in Illinois, Florida, Texas, and California. We found, on average, that 65 percent of the patients in hospice over 210 days did not qualify for the benefit. From these audits we identified $83 million in overpayments. In addition to the problem of overpayments, these audits discovered other problems regarding internal controls, questionable hospice marketing practices, and potential illegal incentives to refer nursing home patients to hospices. We have ongoing investigations.

Special Vulnerabilities for Nursing Home Patients.

Beginning in 1986, Medicaid nursing home patients were allowed to elect hospice care. Recently we have begun to look closely at hospice patients residing in nursing homes. We are finding that nationally approximately one-fifth of hospice patients residing in nursing homes were ineligible for the benefit. Approximately one-third of those that lived beyond 210 days had been ineligible for the benefit when they enrolled.

When a nursing home patient elects hospice, the hospice assumes responsibility for the professional management of the patient's medical care, but the nursing home continues to provide the patient's room, board and other services. The payment system for hospice patients residing in nursing homes is complex, involving a transfer of funds from the State Medicaid program to the hospice and then a payment by the hospice to the nursing home. The average amount that the States transfer to the hospices is $73 per day per patient. The hospice may transfer some, all, or more than this back to the nursing home to cover routine daily needs. The hospice also receives the same level of payment from Medicare for providing hospice services to these patients as it does for patients residing at home—$96 per day. The end result is that both the nursing home and hospice receive payment for providing services to beneficiaries residing in nursing facilities. We are currently looking at the type and frequency of the services being provided to these patients. Many times we are

finding that hospices are providing routine care that is being provided by the nursing home, and usually fewer services than they provide to patients at home.

Another factor affecting the increase in hospice payments may be the 1990 repeal of the 210 day limit for hospice care. Prior to 1990, hospices were more conservative in deciding who would be admitted under the benefit and when to admit the patient. If the patient lived beyond 210 days (7 months), the hospice would have to absorb the cost of providing care to the patient since Medicare would not pay beyond this time. Repeal of the 210 day limit shifted the financial risk for patients living longer from the hospice to Medicare. Prior to the repeal of this limit, less than 6 percent of hospice patients lived beyond 210 days. In early 1996, however, approximately 14 percent of patients had lengths of stays longer than 210 days.

Let me be clear that we recognize that some of the longer stays may be a positive development, perhaps reflecting the fact that hospices are providing care that is beneficial to the patients and resulting in longer life. Furthermore, we recognize how difficult it is to predict how long even a seriously ill person may live, and we fully expect that some hospice patients will live beyond initial estimates made by physicians. What we are concerned about is patients whose medical condition never did support a prognosis of death within 6 months (as required for eligibility for the Medicare hospice benefit). For example, our audits found patients with "unspecified" debility, or with Alzheimer disease or other chronic or lingering conditions which at the time of admission to the hospice program were not likely to be terminal within six months.

We are very concerned about these patients not only because their admission to the hospice program may be contrary to Medicare guidelines, but also because their health and well being could be jeopardized. Election to the palliative care offered by this program requires beneficiaries to voluntarily relinquish their right to curative care for their terminal condition under the regular Medicare program. However, it may be that curative care is what they need. Being deprived of it for more than 210 days could be harmful to them. It is true that these patients may decide to return to the regular Medicare program. However, once they have been in hospice care for more than 210 days, they never again have the right to choose hospice care should they ever need it.

Administrative Remedies.

We will continue to investigate hospice providers who are blatantly enrolling Medicare beneficiaries that do not qualify for the benefit. We are also urging the Health Care Financing Administration to provide better oversight of the hospice program by educating the provider community and examining hospice claims more closely.

Legislative Amendments.

However, we believe that Congressional action is warranted to address inappropriate growth of the hospice benefit. Consideration should be given to reducing Medicare payments for hospice patients living in nursing homes. This would be consistent with the overlap of services received by these patients under both the nursing home and hospice programs. In addition, it may be appropriate to reduce Medicare payments for hospice patients after 210 days. This would result in hospices appropriately sharing the risk for recruiting patients. It would provide an incentive for them to ensure that only those beneficiaries who meet Medicare guidelines are enrolled in the program, while still affording a level of financial protection for them and resources to serve those patients who outlive the six month prognosis.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Medicare Part B pays for medically necessary medical equipment and supplies furnished in a beneficiary's home when ordered by a physician. Durable medical equipment consists of items that can withstand repeated use and include oxygen equipment, hospital beds and wheelchairs. Medical supplies include catheters, ostomy, incontinence and wound care supplies.

General Fraud and Abuse.

Over the years, we have devoted significant resources to issues involving medical equipment and supplies. We have seen problems associated with filing claims for equipment that was never delivered, upcoding, unbundling, providing unnecessary equipment, and excessive payment rates. The widespread problems in this area have been due in part to high profit margins, ease of entry into the system, and weaknesses in payment safeguard functions. Some of our more significant work in this area includes:

• Enteral Nutrition Therapy—We found that Medicare payments for enteral nutrients are excessive. Nursing homes and other third party payers are able to purchase enteral products at rates 17 to 48 percent less than Medicare allows. Even a 17 percent reduction in Medicare payments would have saved the program $45 million in 1994.

• Wound Care Supplies—We found that questionable payments of wound care supplies may have accounted for as much as two-thirds of the $98 million Medicare allowed for these items from June 1994 through February 1995.

• Incontinence Supplies—We found that questionable billing practices may account for almost half of the $230 million allowed for incontinence supplies in 1993. We have convictions for providers billing for incontinence supplies that were never delivered.

• Oxygen Services—We found that Medicare, on the average, allowed 174 percent more than the Veterans Administration reimbursement for oxygen concentrators. We also found significant variation in the services provided to beneficiaries associated with oxygen concentrators. Reducing Medicare's payment to one that is more compatible with Veterans Administration prices, while still adjusting for difference in procurement requirements and methods, could save Medicare $200 million per year. At the same time, standards for services and quality assurance can and should be tightened.

• Orthotic Body Jackets—We reported that 95 percent of claims paid by Medicare ($14 million in 1992) were for non-legitimate devices. We have also obtained convictions of entities that billed Medicare for body jackets when they actually provided seat pads.

• Nebulizer Drugs—We found that Medicare and its beneficiaries could have saved $37 million if they had used the payment methodology used by Medicaid for nebulizer drugs.

Special Problems in Nursing Homes.

We have particular concern when these medical supplies and services have been furnished in a nursing facility setting. Above and beyond any payment that might be made by Medicare Part A for skilled nursing home care or by Medicaid or private insurance for long term nursing home care, Medicare Part B pays for services and supplies provided to Medicare beneficiaries residing in a nursing home. The service provider is the one who bills Medicare for this, not the nursing home. In fact, the nursing home may have very little to do with authorizing or overseeing the service provided and has little to say about the cost to either the Medicare program or the beneficiary. We have found that no single individual or institution is held responsible by Medicare for managing the beneficiary's care and medical services while in a nursing home. Without appropriate oversight, the opportunity and incentive certainly exists to aggressively market and promote excessive and unnecessary items and services.

For example, a Medicare Part B provider who offers therapy services to residents of nursing homes can easily gain a market for his or her services. The patient is happy to receive services of any kind, with the expectation that they may help medically or socially, and the nursing home staff is relieved of patient care during the time the provider is delivering therapy services to the patient. While such services and supplies must be authorized by a physician, we have found that the oversight of physicians in these cases is often very weak. When suppliers deliver unneeded and unordered supplies to nursing homes for patients and bill Medicare, the nursing home has little incentive, except for limited storage space, to return the supplies.

In the nursing home setting, we have also become increasingly concerned about the cost shifting between Part A and Part B of the Medicare program in the provision of services for skilled nursing facilities. The Health Care Financing Administration determines the daily rate it will pay for care in a skilled nursing facility. This rate is calculated to include the totality of services, including room and board, nursing care, and other routine services. However, for some additional services, such as enteral nutrition, rehabilitation therapy, surgical dressings, incontinence supplies, and braces, skilled nursing facilities are permitted to bill Part B of Medicare separately.

Administrative Remedies.

I am pleased to report that in addition to discovering problems we are also developing new and effective ways to deal with them. One good example is the problem with incontinence supplies which I mentioned above. Our exposure of these billing abuses, coupled with a coordinated nationwide investigation involving more than 20 separate cases and a concerted effort by the Health Care Financing Administration's durable medical equipment carriers has turned the escalating reimbursements

downward. By the end of FY 1995, the abusive practices we had identified had all but disappeared and Medicare is now saving more than $104 million per year as a result.

Legislative Amendments.

While this kind of action is good news, it is not enough of a solution. It is important to get at the underlying systems which leave Medicare so vulnerable to this kind of abuse.

Because of our concerns related to nursing home payments, we believe it is appropriate to enact global payment restructuring. Structural changes can include combining payment for supplies and equipment into the nursing facility daily rate, consolidated billing, competitive bidding strategies, and capitation payments. Each of these strategies attempts to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients with the cost savings passed on to Medicare. Additionally, these payment mechanisms recognize the importance of the nursing facility in achieving a more cost effective program. Since nursing facilities are significantly involved in the planning and provision of patient care, they arguably, are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the services and supplies needed to meet the medical needs of their patients.

We believe that changing the payment incentives in the nursing home area will be effective in reducing some of the abuses we have found with durable medical equipment. However, additional action which specifically addresses durable medical equipment, such as conducting site visits to oversee suppliers, requiring suppliers to obtain surety bonds, and charging application fees should also correct abuses. Finally, additional legislative modifications such as making it easier for the Health Care Financing Administration to reduce inherently unreasonable payment levels and authorizing competitive bidding should be considered.

OTHER AREAS OF CONCERN

Other programmatic areas which are of continuing concern to us are lab services, prescription drug prices, and non-physician outpatient services. Following is a brief summary of our findings and recommendations in this area.

• Lab Services—We are nearing completion of a three-year investigative initiative called "LabScam." LabScam is targeted at abusive marketing and billing practices by the Nation's largest independent clinical laboratories. This project evolved from a 1992 case against National Health Laboratories involving "unbundling" of tests. Unbundling is the practice of running specimens through a single piece of automated multi-channel laboratory equipment and then billing separately for each component test. The frequency of testing for the Medicare population increased 96 percent from 1986 to 1993, while the population increased by 14 percent.

In coordination with other Federal and State law enforcement agencies, our LabScam investigation has generated receivables and recoveries to date of over $800 million. We have recommended the Health Care Financing Administration periodically evaluate the national fee schedule to ensure that it is in line with the prices that physicians pay for clinical laboratory tests and to develop policies and procedures to ensure that the Medicare program benefits from reduced prices when panels are ordered on behalf of Medicare patients.

• Prescription Drugs—Medicare beneficiaries receive limited coverage only under this benefit which covers certain prescription drugs, mostly administered by physicians, and used for cancer/pain management, dialysis, organ transplantation, and immunization. Medicare paid nearly $2 billion in 1995 for over 700 million drug units, as compared to $663 million in 1992.

Medicare drug allowances are based on average wholesale prices which are recommended by manufacturers but do not accurately reflect actual wholesale prices. This results in payments significantly more than those paid by Medicaid, mail-order pharmacies, and even some pharmacies. We have recommended that Medicare payments for prescription drugs be based on acquisition costs paid by the biller subject to a median limit. Potential savings could be as much as $450 million per year based on adoption of this recommendation.

• Non-Physician Outpatient Services Claims—Since the inception of the prospective payment system in 1983, hospitals have improperly billed Medicare for non-physician outpatient services that are included in the hospital's inpatient payment. We have issued a series of four reports identifying about $115 million in Medicare overpayments to hospitals for improper billings from 1983 through 1991. A fifth report has revealed that the problem continues, and has identified over $27 million in improper billings and subsequent payments from 1992 through 1994. Since an

improper billing pattern has been repeatedly demonstrated among the hospital community, the identified claims are being subjected to the Federal False Claims Act. To date, over $100 million has been recovered.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you some of our concerns related to the Medicare program. The problems I have described today have a direct impact on the solvency of the Medicare Trust funds, and their elimination would help improve the financial viability of these trust funds. There are other problems as well. Each year we issue our Cost-Saver Handbook, also known as "The Red Book," which summarizes all of our major dollar recommendations that have not been substantially implemented. Consideration of our recommendations, both in this testimony as well as those contained in "The Red Book," would contribute toward solving this financial crisis for present, as well as future, Medicare beneficiaries. I would be happy to make any of our reports available to the Subcommittee and to also respond to any questions you may have.

Chairman JOHNSON. Thank you very much for your excellent testimony.

Ms. Lau, in the past 2 years, the Office of Internal Affairs at Customs has handed down several indictments against Inspectors on the Southwest border. The indictments concern instances in which corrupt Inspectors contacted drug smugglers using cell phones and pagers to indicate which border crossing lanes would facilitate illegal drug shipments by car.

The right to wear these electronic devices has been defended and permitted by Customs management under the partnership agreement. What efforts have been made by your office to pursue such cases of corruption within the Customs Service?

Ms. LAU. Yes, Madam Chairman, you may be aware that, especially at the Southwest border, there is a Southwest border task force that is headed by the FBI and includes the participation of Customs and DEA. They have taken a lead role in the area of investigations into border corruption cases such as this.

Chairman JOHNSON. And what kind of effort has been made to deal with the issue of laundering money, since one of the chief ways of laundering money is to overstate the value of imports?

Ms. LAU. Madam Chairman, in that area Customs, itself, has implemented at least one program that does address the valuation of imports. It is called the compliance measurement program. And in that program, there are criteria that would address whether the import is appropriately valued and the appropriate duties assessed. I understand in their most recent report they have reported over 80-percent compliance.

Chairman JOHNSON. Over 8-percent compliance?

Ms. LAU. Yes, that is my understanding.

Chairman JOHNSON. That does not sound very high.

Ms. LAU. Over 80-percent compliance?

Chairman JOHNSON. Oh, 80 percent. I thought you said 8 percent.

Ms. LAU. Eighty percent. I am sorry.

Chairman JOHNSON. I see.

Ms. LAU. Eighty.

Chairman JOHNSON. And have you reviewed this program? Would you agree with them on that?

Ms. LAU. In this area, that is one of the programs in place that we look at in conjunction with our financial audit review. But in terms of programmatic review, I do not believe we have yet reviewed the effectiveness of the program.

Chairman JOHNSON. And by 80-percent compliance, I assume that you mean that 80 percent of the shipments are not being overvalued?

Ms. LAU. To be precise, I would like to look into that and report back to you on the record.

Chairman JOHNSON. What I would like to know is, what was the compliance level before? I mean, do we have any idea? I would assume, actually, that the number of shipments involving laundering would be rather small; just the value very high. So 80-percent compliance may have been there before and there now, and not have touched the problem. So you can get back to me on that.

Ms. LAU. I am afraid I do not know what the baseline was, as we were talking before about measurement, that it is important to know what baseline you are measuring that against. So I would be happy to provide that for the record.

[The following was subsequently received:]

The Compliance Measurement Program (CMP) is Customs' primary tool to assess compliance of port of entry transactions across the 4-digit Harmonized Tariff Schedule (HTS). Among the compliance issues covered during CMP are value, quantity, quota, classification and country of origin. Customs developed initial baseline data on import compliance across the 4-digit HTS for the first time in 1995. In 1996, Customs refined and expanded the measurement of this baseline data.

The results showed nationwide, an overall increase in compliance from 80 percent in 1995 to 82 percent in 1996. Customs' 1996 data also show that discrepancies in the stated value of imports occurs about 1 percent of the time nationwide. These discrepancies can be both over values and under values. In 1995, Customs projected $83 million in revenue over collections and in 1996, $101 million.

I do not have any information on how much, if any, of these overcollections or discrepancies in values result from the practice of overstating the value of imports as a means of money laundering. My office would not normally have investigative jurisdiction in this area unless there was indications of involvement by Customs officials in the money laundering scheme. Customs Office of Enforcement would have jurisdiction to investigate illegal practices by importers or brokers. I do know that Customs has enforcement initiatives on the southwest border such as Operation Hard Line aimed at drug smuggling and money laundering. They could speak more specifically to efforts underway to combat the various money laundering schemes.

Chairman JOHNSON. Thank you.

Mr. Coyne.

Mr. COYNE. Thank you, Madam Chairwoman.

I wonder if you could, Ms. Dalton, expand on the extent of the abuse relative to 401(k) pension plan assets? Is that an extensive problem?

Ms. DALTON. In the first 14 months of the operation of the employee contribution project of the Pension Administration, there were approximately 1,200 cases that were opened. And there were some significant recoveries from that work.

Mr. COYNE. How would the typical employee know if their contributions were not deposited to their 401(k) plan or are diverted? How would they be able to tell that?

Ms. DALTON. One of the problems that was identified and addressed by the Pension Welfare Benefit Administration was the fact that, many times, an employee was not aware of that. The administration went through an education process, so that people would become more aware and would be looking at reports and statements from their pension plans to determine the condition of the plan.

Mr. COYNE. Is the bigger problem diversion of funds after deposit, or failure to deposit the contributions?

Ms. DALTON. I cannot give you a definitive answer on that. There have been problems in both areas. In terms of before the deposit occurs, one of the things that has happened recently is that the amount of time allowed for the employer to hold the money has been reduced from 90 days to 15 days. And it is a violation of the ERISA Act if that money is not deposited in a timely manner. So there is a reduced period in which that money can be used prior to the requirement to deposit the funds.

Subsequent to deposit, there are continuing problems with fraud and abuse in this area. We have had numerous cases in this area where money has been diverted to investments that were not in the best interests of the plans and, in fact, the plans were defrauded.

Mr. COYNE. In your overall findings, are union employees more susceptible to the risk of fraud, more so than nonunion employees?

Ms. DALTON. I do not know the answer to that. Both union employees and nonunion employees can be and have been victims of fraud and abuse. Whether it is more in one or the other, I just do not know.

Mr. COYNE. You would not be able to tell us that?

Ms. DALTON. No.

Mr. COYNE. Thank you.

Chairman JOHNSON. Mr. Tanner.

Mr. TANNER. Thank you, Madam Chair.

Mr. Mangano, you, I assume, heard the GAO testimony about the number in the case of fraud and abuse, and so on, in the Medicare Program put at $6 to $20 billion. Do you have an idea about that?

Mr. MANGANO. Well, we have never developed any independent estimate of that figure. We have always known about the GAO estimation based on other reviews. What I can tell you is that wherever we look we do find problems. The largest portion of that fraud, waste, and abuse figure is in the waste area, and those things come into play where we believe Medicare pays too much for things. They do not get fair-market value for the kinds of products that they purchase.

We are, as I think Mr. Dodaro mentioned earlier, conducting the Chief Financial Officer audit of HCFA this year. By this summer I think we may be able to give you better figures on what the estimation is for fraud and abuse.

Mr. TANNER. Well, I think that would be helpful, simply from the standpoint of being able to measure progress on the point. And whatever you could do there would be very much appreciated.

On this Operation Restore Trust that has been talked about in the five States, what did you identify, or what was identified, I

guess, as the primary sources either gross overutilization or out and out fraud?

Mr. MANGANO. Well, the three areas that we targeted in the Operation Restore Trust were home health, durable medical equipment, and nursing facilities. And as I indicated earlier in my testimony, we think that the home health benefit is the area that is most prone to abuse in these days. The mushrooming of the number of home health agencies has been astounding over the last 5 or 6 years.

There are several reasons for it. One, it is a very generous benefit. It is a benefit which is provided in a person's home, so there is really not much oversight of it. There is no copayment from the beneficiary's point of view, so the beneficiary in many cases really loses some of the added incentives to ensure that the benefits are appropriate.

The last thing is that the benefit itself has to be authorized by a physician, and a physician has to order a plan of care. In many of the cases, we are finding that the physicians that are actually signing some of these plans of care are not the beneficiaries' personal physicians, but physicians that may be hired by the home health agency, which has every interest in signing up new beneficiaries and then allowing for very many more visits.

One of the questions that came up a little earlier this morning from a Subcommittee Member pertained to some of his beneficiaries complaining about fraud in the home health area. We have seen that time and time again. The organizations that have been in this business for a long time, that have been providing this service before the benefit took off, are really some of the finest providers of home health services that we have seen. It has been many of the new for-profit entrepreneurs that have gotten into the business to make a fast buck that have given it the problems.

Once we discover that there has been a fraudulent or abusive situation occurring, we will issue a report and we will start an investigation; but many times that home health agency will go immediately out of business because the primary source of revenue is Medicare. So once we do identify how much they owe in terms of false billings, there is no way to collect that money again, because the business is defunct.

Mr. TANNER. Does the State have a role in this at all, in terms of law enforcement?

Mr. MANGANO. Certainly, many of these home health agencies that do business with Medicare also do business with Medicaid, and the State operates the Medicaid Program. I believe there are some States that have additional programs to ensure the integrity of some of these home health agencies.

One of the panelists this morning mentioned that Florida has gone to a surety bond system, which is something that we have recommended as well, so that the organizations need to be bonded in their State. We think that there ought to be reviews of applications that are a lot tighter than they have been to date, so we can ensure that the fly by nights do not do business with us.

Mr. TANNER. With respect to that, what has happened on your recommendation that a surety bond be put in place so that you get

at the problem of these people closing up when you discover they are running a scam of some kind?

Mr. MANGANO. We have made that recommendation. HCFA said that they are looking at it. We do not have a final decision on it.

One of the things I am very hopeful about is that the administration has now come forward with a proposal to pay for home health services on a prospective basis. And I know the Congress is taking up that same initiative. So I think some of the policy recommendations that we have made HCFA is following up on. They are doing certain things with their carriers and intermediaries to have closer scrutiny toward some of these bills.

HCFA, for the first time, has involved its survey and certification organizations into going into home health agencies to make sure that they really are properly doing business.

Mr. TANNER. Thank you. One followup on that. In the situation you described—the fly by nights, you call them—what happens when they go out of business and, of course, there is no money to collect from the overpayments or the fraudulent payments, however one wants to characterize them? Is there a communication from your office to the Justice Department or to the State attorney general? What happens there?

Mr. MANGANO. Absolutely. When we find a situation of fraudulent billing, we almost always open up a criminal investigation and work with the Department of Justice to bring those persons to the bar of justice. The money, if it does not exist in the corporation, is gone. But we do follow up.

One example of that was an organization down in Georgia. It was one of the largest home health agencies in the South. The original name was "ABC Home Health Products," and they changed it to "American Home Health Products." We initiated a criminal investigation. Both the owner and his wife are now in jail, and that organization paid back $252 million to the Federal Government.

Mr. TANNER. We should do more of that.

Chairman JOHNSON. That is pretty impressive.

Ms. Dalton, I would like to ask you a few questions about pension policy, as well. You call for the repeal of the limited-scope audit provisions. It is my understanding that there are no audit requirements for employers with fewer than 100 employees.

Ms. DALTON. That is correct.

Chairman JOHNSON. And of those employers that have 100 to 500 employees, half of the employees in that category have no pension coverage.

Ms. DALTON. I am not sure of that, Madam Chairman.

Chairman JOHNSON. Well, but assuming that that is the case—because it was part of, I guess, an earlier GAO study—I assume, then, that the fees for audit would be distributed over half of the companies that have employees between 100 and 500. And I would like to get some estimate from you, either now or later, as to what you think the cost of that audit would be.

Ms. DALTON. We had an estimate several years ago from the American Institute of Certified Public Accountants that they believe that the additional cost for full-scope audits for those half of the plans that are not currently getting the full-scope audit would be an increase in their audit cost of 10 to 30 percent.

Chairman JOHNSON. An increase in their audit cost of 10 to——
Ms. DALTON. Thirty percent.
Chairman JOHNSON. Of 10 to 30 percent?
Ms. DALTON. That is correct.
Chairman JOHNSON. That is important, because the Federal Government made a series of changes in pension law some years ago that had the result, the unintended consequence, of motivating many companies to drop their pension plans. Now, if your audit costs go up 30 percent, we may provoke a similar unintended consequence.
Also, your testimony states that $950 billion in pension plan assets are not examined because of the limited-scope audit provision. But how much of this money is already in regulated institutions?
Ms. DALTON. The limited-scope audit provision can be invoked for the assets that are included in federally or State regulated institutions, such as savings and loans, insurance companies, and so forth.
Chairman JOHNSON. Excuse me. What is the need for taxpayer dollars invested in investigating assets that are in financial institutions that are already regulated by Federal law?
Ms. DALTON. Well, I think there are two reasons. First of all, what happens is, part of the assets but not all of the assets, may in fact be in regulated institutions. Because of the assets that are not subject to audit, the auditors are often in the position that they must disclaim an opinion on all assets, even those they are supposed to have looked at.
Chairman JOHNSON. Ms. Dalton, do you have any information on what percentage of the pension moneys currently not overseen by you are not in regulated financial institutions?
Ms. DALTON. No, I do not.
Chairman JOHNSON. Well, I would certainly want to know that fact before I made a change in the law. And the second fact I would want to know is why auditors are not required currently to provide the split opinions they used to provide, which would enable you to have the information as to how much of this money is in financial institutions and how much really needs auditing.
Ms. DALTON. Currently, under generally accepted auditing standards, auditors are not allowed to give what is called a piecemeal opinion. They must give an opinion on the financial report as a whole. The reason for this is that if they cannot attest to certain accounts, the activities in those accounts may affect other assets, liabilities, other transactions within the plans. So therefore, the auditors are in the position of basically giving no opinion. They do some work on the plan, which is paid for, but no opinion is given.
Chairman JOHNSON. All right. We certainly would want to look at restoring to the auditors a somewhat more flexible approach, when I would suspect that most of these moneys are in financial institutions in which there is already oversight. So if you would get back to us on that, certainly it will affect our ability or interest in moving ahead.
And I am going to yield now to Mr. Hulshof.
Mr. HULSHOF. Thank you, Madam Chair. To follow up just a little, Ms. Dalton, if an accountant audits a business in my district, it is reasonable for the accountant to question the value of assets.

Should it not also then be reasonable to use that same scrutiny for pension plans?

Ms. DALTON. Yes, it is.

Mr. HULSHOF. The Chair asked a question about the increased cost—you mentioned 10 to 30 percent—of additional administrative cost. I ask the question directly. Is this not going to require, or would businesses not be more reluctant to provide pension plans for employees if their costs were to go up in that significant fashion?

Ms. DALTON. The 10 to 30 percent, I think, has to be put into some perspective, in that pension plan audits are often an add-on audit to the overall corporation audit. So even though the percentage sounds fairly high, the actual cost of a pension plan audit may be fairly small relative to the total corporation audit. And oftentimes, the same auditor is doing both the corporate audit and the plan audit.

Mr. HULSHOF. I am not sure when you came in for the previous panel, but one of the things we talked about was the information security problems and some of the things GAO was concerned about regarding computer attacks, if you will. And you mentioned that more needs to be done maybe to improve information security at IRS. Could you give us just a couple of ideas about what you think should be done to improve information security at IRS?

Ms. LAU. Yes, I would be happy to. You are referring to my statement in which I outline some of the work the Chief Inspector's Office and my office have done in the area of information security, which is part of the basis for my statement that more needs to be done.

The one example that I used specifically is a followup review of information security over small scale computer systems that the Chief Inspector conducted where weaknesses previously identified several years ago still exist. That is the kind of issue of follow-through that was mentioned in the prior panel.

I can only provide you examples based on the work we have done, but we certainly would be, the Chief Inspector and I, amenable to coming up to talk with you or your staffs about the issue further.

Mr. HULSHOF. Last, I guess a question for each of you. Mr. Mangano, probably every one of us on this Subcommittee—in fact, probably every one of us in this body—could provide horror stories that happen in the field regarding fraud and abuse. And because this was just communicated to me recently back in my district: A practicing nurse involved in home health care had gone to her routine visit of a man who was receiving the health care at home. And he was ambulatory—he was shopping—and so clearly did not qualify for the home health visit. When she mentioned this to her superiors at the health facility, and she was encouraged to change her nursing note to indicate that, in fact, the gentleman did require home health visits.

What can I tell that woman? And as a result of that, by the way, she made the decision to, on her own, terminate employment with that home health facility. Rather than have her give up her career, what can I tell her and others in that situation as to how their concerns regarding fraud or abuse can be addressed?

Mr. MANGANO. Well, that is clearly a case of fraud, and it is the kind of thing that we see all the time when we go out there and look at some of these home health agencies. That person can report it to our office, or could go to the regional home health intermediary and report it there. That is the intermediary that is contracted by the Health Care Financing Administration to operate that benefit. Either one of those two places is fine with us.

And an easy way to remember our phone number is, she can report it on our hotline, which is "HHS–TIPS"—T–I–P–S.

Mr. HULSHOF. If the Chairwoman would indulge me in a last question, what is there for concerns, whether they are real concerns or just perceived concerns, then that somehow she would be blacklisted in the future? I mean, the information that she would want to provide to the appropriate authority, how can she be assured that something like that would not follow her around in future employment possibilities?

Mr. MANGANO. I do not know that there is any guarantee that I can make out of it. But I would say this, that she would have an awful lot of admiration from those home health organizations that run a reputable business. She is obviously working for either a company or an individual as her supervisor that are not running a proper business.

Mr. HULSHOF. Thank you, sir.

Thank you, Madam Chairwoman.

Chairman JOHNSON. Thank you. I did want to ask one more question of you, Ms. Dalton. The administration has recently created an economically targeted investment program to allow plan sponsors to make investments on the basis of guidelines issued by the Labor Department. Can you tell me how many applications have been submitted——

Ms. DALTON. I am sorry——

Chairman JOHNSON [continuing]. And how many you have approved? You know, the administration has developed this economically targeted investment program to allow plan sponsors to make investments on the basis of guidelines issued by the department. And I am wondering how many applications have been submitted to do that to the department, and how many you have approved, and what criteria you use in approving or rejecting them?

Ms. DALTON. I am sorry, Madam Chairman. I do not have that information available, but we will attempt to get it for you.

Chairman JOHNSON. I hope you will get it back to me. Because I share with you the belief that government has an absolute responsibility to assure that pension contributions get deposited and get protected. But I believe that your guidelines are going to allow some investments of a type that were made in Connecticut into high-risk investments. And we have seen companies lose considerable money, and the State lose considerable money, through those kinds of investments.

So if you would get to me the guidelines that you use, the number of applications, the number approved, and why, that would be helpful to me, because I have real concern that this program is in opposition to our shared goals, rather than in support of those goals.

Ms. DALTON. Yes.

[The following questions and answers were subsequently received. An attachment is being held in the Committee files.]

U.S. Department of Labor

Office of Inspector General
Washington, D.C. 20210

MAY 14 1997

The Honorable Nancy L. Johnson
Chair, Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chair:

During my testimony before your subcommittee, you requested that the Department of Labor provide for the record answers to five questions. Since the questions were largely of a program nature, we contacted the Department's Pension and Welfare Benefits Administration (PWBA), since it is best suited to provide the Subcommittee with the necessary information. We have just received PWBA's responses and are forwarding them with OIG comment, where appropriate.

1) COSTS OF AUDITS

QUESTION: What is the cost of a full-scope audit vs. a limited scope audit?

ANSWER: As stated at the hearing, several years ago the American Institute of Certified Public Accountants estimated that requiring full scope audits for plans that currently get limited scope audits would increase their audit costs by 10 to 30 percent.

PWBA indicates that, according to a 1996 study by Hay-Huggins (Enclosure 1), the cost paid for auditors' fees by a typical defined benefit plan with 500 participants is $14,287. Therefore, 10 percent of this amount would be an increase of $1,428 and 30 percent would be $4,286.

Total administrative costs for such a plan were calculated to be $86,810 (or 0.58% of payroll). Using this range of estimated costs, PWBA estimates that total administrative costs for affected plans would increase from 1 to 5 percent.

2) AMOUNT OF ASSETS IN REGULATED FINANCIAL INSTITUTIONS

QUESTION: How much of the $950 billion in pension assets (that is not currently subject to full scope audits) is already in regulated institutions?

ANSWER: PWBA does not have a source of data to be able to differentiate between plan assets that are or are not held in regulated financial institutions. However, PWBA's experience in working with these plans and their filings is that virtually

all plan assets are held in regulated financial institutions. One of the OIG's concerns is that those assets need to be fully reviewed by accountants that have technical expertise in ERISA requirements, which currently is not necessarily the case. Moreover, an OIG audit disclosed that assets held in financial institutions received widely varying audit coverage. The audit found that reviews of these pension assets were conducted irregularly leaving assets held by those institutions potentially vulnerable.

3) PERCENTAGE OF ASSETS WITHOUT FULL SCOPE AUDITS

QUESTION: What is the percentage of pension monies currently not overseen by you and which are not in regulated financial institutions?

ANSWER: As indicated in the answer to Question 2, PWBA cannot break out the portion of these assets that are not held by regulated financial institutions. However, PWBA believes this would be a relatively small portion of the total. Nonetheless, the OIG's concerns involve the assets held in regulated financial institutions.

4) AUDITOR'S OPINION ON ASSETS NOT HELD BY REGULATED FINANCIAL INSTITUTIONS

QUESTION: Why are auditors not required to provide split opinions they used to provide, which would enable you to have the information as to how much of this money is in financial institutions and how much really needs auditing?

ANSWER: Professional auditing standards established by the American Institute of Certified Public Accountants [AU 508 which codifies SAS 58 (Enclosure 2)], specifically prohibit auditors from issuing piecemeal opinions when an auditor has disclaimed an opinion on the financial statements taken as a whole.

5) ECONOMICALLY TARGETED INVESTMENTS

QUESTION: Regarding DOL's economically targeted investment program:

(A) How many applications have been submitted to DOL for its economically targeted investment program?

(B) How many have you approved?

(C) What is your criteria for approving them? What are the guidelines for this?

ANSWER: According to PWBA, the Department of Labor does not have an economically targeted investment program. Thus, no applications are submitted to DOL for an economically targeted investment program and none have been approved. The Department of Labor does not have a program or policy of approving specific plan investments, economically targeted or otherwise.

PWBA indicates that the Department of Labor has clarified in a bulletin issued in 1994 that economically targeted investments are governed by the same ERISA standards as other plan investments. Plans may invest in economically targeted investments if those investments are expected to provide risk-adjusted rates of return commensurate with competing investments of similar characteristics and the investment is otherwise appropriate for the plan in terms of such factors as diversification and the investment policy of the plan.

In 1994, the Department provided initial, start-up funding for a privately based information clearinghouse to collect and disseminate information about economically targeted investments. The clearinghouse does not accept applications for economically targeted investments, nor does it approve them. According to PWBA, the Department does not currently provide funding for this entity, nor does it exercise control or approval over the operations or investments listed with this information clearinghouse. The information clearinghouse had been recommended by a bipartisan group, the ERISA Advisory Council, which identified a need to provide accurate information in this area.

I would like to thank you again for the opportunity to testify before your Subcommittee on the need to ensure the integrity and security of pension plan assets. Should you or your staff have any additional questions, please contact me or Sylvia Horowitz, Assistant Inspector General for Management and Counsel, on 219-4930.

Sincerely,

Patricia A. Dalton

Patricia A. Dalton
Deputy Inspector General

Enclosures

Chairman JOHNSON. Thank you very much. And thank you to the panel. Unless anyone else has any further question—any?

Thank you very much. It has been a very useful hearing.

[Whereupon, at 1:17 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of John J. Callahan, Acting Commissioner of the Social Security Administration, on the Program Integrity of the Supplemental Security Income Program

Madam Chairman and Members of the Subcommittee:

Thank you for the opportunity to address several issues raised by the General Accounting Office (GAO) during the March 4, 1997, hearing before your Subcommittee, on the Supplemental Security Income (SSI) program.

Let me first acknowledge that GAO's input can be a valuable resource in identifying areas in which improvements might be needed. I am concerned, however, that GAO's March 4 testimony before your Subcommittee may have been misleading, because it did not fully reflect the many steps SSA has taken to improve the administration of the SSI program and protect it from fraud and abuse.

INTRODUCTION

Mr. Chairman, SSI was designed to provide a basic measure of financial security for the neediest and most vulnerable among us elderly, blind and disabled individuals who have very little income or assets. That is why we at SSA have a "zero tolerance rule" for those who would seek to defraud this vital program. SSI is the primary financial support for six and one-half million low-income elderly and disabled Americans more than half of whom have no other source of income at all.

Given the size and complexity of the SSI program, we are constantly working to improve its administration, and to enforce this zero-tolerance rule. Let me now outline some of the specific measures that have been taken over the past few years.

INITIATIVES TO COMBAT FRAUD

During fiscal year 1996, SSA developed a comprehensive tactical plan to focus the necessary resources and provide appropriate oversight in a consolidated effort to combat waste, fraud and abuse. The Commissioner established a National Fraud Committee and ten Regional Fraud Committees to oversee the implementation of the plan. These Committees will ensure that SSA's efforts to combat fraud will be supported and implemented effectively.

Because State assistance programs are often linked to SSI eligibility, State and federal interests in fraud investigation often overlap. Therefore, SSA is taking steps to team with State and local authorities to investigate likely fraud cases. SSA is also moving aggressively to develop mechanisms, such as computer matching agreements, for obtaining and verifying income and other relevant information about SSI recipients from States and other public agencies. For example, SSA is currently engaged in an ongoing pilot project in Tennessee which has resulted in the capability of SSA claims representatives to use the highly automated system of birth, death and employment records in that State.

It should be understood, however, that it is neither a quick nor an easy task to expand this pilot to other States. Rather, SSA will have to negotiate separate agreements with each State, and with each State agency, since each State has separate data sources and different hardware and software configurations. Indeed, many States do not have centralized data at all. However, the results of the pilot in Tennessee augur well for future expansion of data-sharing, and we are pursuing this goal aggressively.

THE SSA OFFICE OF THE INSPECTOR GENERAL (OIG) AND NATIONAL FRAUD HOTLINE

Our ongoing efforts to fight program fraud and abuse were greatly enhanced when Public Law 103–296 was enacted, establishing SSA as an independent agency, effective March 31, 1995, with its own Inspector General (IG). SSA and our IG's office have forged a strong relationship which has already borne fruit: through our joint efforts, in fiscal year 1996, 570 individuals were convicted of fraud and more than $22 million in fines, judgments and restitutions were recovered. Of this amount, about $1.3 million is related to SSI fraud. We look forward to continued success in our joint efforts.

To help identify cases of potential fraud, we have established a national fraud hotline (1–800–269–0271). Using this hotline, we have received leads on potential fraud from our own employees, as well as the public. Moreover, we have increased the number of field personnel investigating reports of fraud by more than 100 percent from 120 to 250 in the past two years.

Fraudulent Transfer of Assets

Let me now turn to the issue of fraudulent transfer of assets, since the GAO has expressed concern that some individuals may dispose of assets for less than fair market value, in order to become eligible for SSI.

SSA developed a provision which was included in the House-passed welfare reform bill, but dropped during conference which provided that individuals who disposed of assets for less than fair market value would be found ineligible for SSI for a period of time directly related to the uncompensated value of the asset.

SSA plans to work with this Congress in an effort to gain passage of this provision.

We would, however, like to point out that we believe that the audit report on this subject was flawed. As we stated in our comments on the report, in a number of the cases looked at during the study, the asset transferred was the SSI recipient's home. An individual's home is not considered a resource under the SSI program and it, therefore, would not have prevented SSI eligibility if held. Thus, data that included transfer of the home should not have been included in GAO's audit.

Improvements in the Disability Related Aspects of the Program

Finally, Mr. Chairman, I would like to discuss SSA's efforts to make improvements in the administration of several disability-related aspects of the SSI program. These include:

- Initial Disability Determinations and Continuing Disability Reviews (CDRs);
- "Middlemen" fraud;
- Return-to-Work strategies and the Administration's "ticket to independence' initiative; and
- Plans to Achieve Self-Support (PASS).

Initial Disability Determinations and CDRs

To improve the way we process claims for both SSI and Social Security disability benefits, we have made a complete redesign of that process this agency's number one priority. We are currently laying the groundwork for a streamlined process that will substantially reduce the time it takes to make a disability determination. It will also provide individuals with more direct access to the people working on their claim.

Of course, we recognize that making a determination of disability is not the end of the process. That is why we redevelop selected cases and conduct myriad reviews, both prior to and after payment to a beneficiary is effectuated, to ensure that development procedures and awards are correct.

In fact, SSA recognized that need to redesign its CDR process long before a GAO audit indicated that need. In 1992, SSA conducted a study which tested the effectiveness of using two tools a mailer and a profiling system as a predictor of medical improvement. Based on this study, the CDR mailer process was implemented in 1993. This process allows SSA to identify more accurately those beneficiaries that are most likely to medically improve, so that we can conduct a full-medical CDR. In contrast, we use a more efficient, cost-effective mailer to conduct CDRs for beneficiaries who are not likely to medically improve. In 1996, SSA implemented computer "scannable" mailers to make the process even more efficient. Since the mailer process was begun, SSA has conducted almost 1 million CDRs.

The number of CDRs processed each year increased from 48.000 CDRs in FY 1993 to 217,200 in FY 1995, but SSA recognized that lack of resources was preventing further progress. In 1996, with full support of the Administration, working with both authorizing and appropriating committees, special funding for conducting CDRs was appropriated and has provided the agency with the ability to conduct many additional CDRs. During FY 1996, SSA processed over 500,000 such reviews the second largest annual number in SSA's history. SSA intends to process 603,000 CDRs in FY 1997, including 151,000 SSI cases. With continued congressional support, we project that we will have processed about 8 to 10 million CDRs (2.4 million in SSI) by FY 2002.

"Middlemen" Fraud

Another potential source of fraud which SSA identified involves the use of 'middlemen' who sometimes help non-English-speaking individuals apply for SSI. It was determined that in some cases these middlemen were attempting to coach individuals to feign disabilities in order to obtain SSI. In other cases, middlemen were taking advantage of individuals who were genuinely eligible for SSI, by charging them exorbitant fees for help in applying for benefits.

In 1992, SSA began working with the leaders in non-English-speaking communities in order to promote trust, to help change some immigrants' cultural belief that they needed the services of a middleman to deal with the government, and to explain the availability of SSA services, emphasizing that these services were free. In addition, SSA has hired almost 1,500 bilingual employees in the past 4 years and currently has the capability of providing translation services in at least 22 different languages.

In our efforts to eliminate the middleman problem, working with the State government in California, 24 arrests of alleged "middlemen" have been made and 18 convictions have been obtained. In addition, 517 SSI recipients have had their benefits terminated.

Return to Work Strategies and the "Ticket to Independence" Initiative

In addressing SSA's efforts to assist SSI beneficiaries to return to work, it is important to understand the statutory limits on SSA's role in decisions regarding vocational rehabilitation (VR).

When the disability program was established in 1954, the Congress stated that one of its objectives was to ensure that disabled individuals were promptly referred to State VR agencies so that as many disabled individuals as possible could be restored to gainful work.

Congress did not, however, establish a single, integrated disability/VR program. Instead, it provided for the coordination of two programs the Federal disability program, administered by the current Social Security Administration, for the payment of benefits to individuals determined to be disabled, and a Federal/State VR program to provide VR services to individual eligible under the terms of a State plan. With respect to rehabilitation, SSA's role was solely to refer disabled individuals for rehabilitation services under the Federal/State VR program, administered by the Rehabilitation Service Administration (RSA) in the Department of Education, and Congress has never changed that role. The State VR agencies make the decisions under the policies set forth by the RSA, and by State VR agencies themselves.

Despite these constraints, in his fiscal year 1998 budget, President Clinton has proposed a new initiative under which SSA, in partnership with the private sector, will help more disabled Social Security beneficiaries return to work and leave the SSI rolls. The proposal would allow SSA to begin a pilot project of a new VR and employment services program under which—

- disabled beneficiaries will be given a 'ticket to independence' which they may use to obtain VR and employment services from any participating public or private provider of their choice;
- SSA will pay only for results. That is, a service provider will be paid only after a beneficiary whom it has served begins to work and no longer receives cash benefits; and
- the Health Care Financing Administration, under a demonstration program, will extend Medicare and Medicaid protection beyond the current-law maximum for some disability beneficiaries returning to work.

Plans to Achieve Self-Support

Mr. Chairman, SSA policies for evaluating PASS plans represent another area of concern. GAO has been particularly critical of SSA for "allowing" individuals to gain SSI eligibility through PASS plans, but SSA has no statutory authority to restrict the use of the PASS provision in this way. Ironically, the legislative history of the provision (that is, the Senate Finance Committee report on H.R. 1) indicates that the Congress wanted SSA to construe PASS provisions liberally in order to encourage individuals' efforts toward self-support.

Nevertheless, we are making additional efforts to bring a greater degree of consistency nationwide in adjudicating PASS applications. For instance, since the February 1996 GAO report on the PASS program, SSA established a cadre of 39 PASS examiners specially trained to evaluate the viability of individual PASS plans. The cadre reviews all PASS plans submitted by SSI claimants. This approach will ensure consistent application of policy and treatment of individuals attempting to establish a PASS.

In addition, SSA has developed a database for PASS specialists to gather management information about the PASS plans they review. We have also developed a standardized form to be completed by an individual applying for a PASS and have refocused our adjudicative efforts from "when" to "how" a plan will be accomplished. That is, we examine the step-by-step process by which an individual plans to meet his or her goal rather than concentrating on whether a plan will meet the required time limits.

Within the next couple of months, this process will undergo a thorough review to determine whether it is the most effective method to ensure that PASS plans offer true opportunity for SSI claimants to move toward a greater degree of independence, while remaining realistic in terms of the individual's desired goals.

In addition, SSA soon will be meeting with representatives from advocacy groups to discuss PASS policies and procedures, and we will also examine this issue in the larger context of our return-to-work strategies.

Prisoner SSI Benefit Cessation

SSA has greatly improved its process for identifying SSI recipients who are incarcerated so that their benefits can be stopped as required by law. Although the requirement for the cessation of prisoner's benefits in was adopted in 1981, it was not until three years ago under the Clinton Administration that serious enforcement was undertaken. SSA has now established reporting agreements with all State and federal prison officials, as well as 99 percent of the 3,500 local and community correctional institutions across the country. Under these agreements, correctional facilities are providing information to SSA about SSI recipients entering prisons. In addition, the welfare reform bill has strengthened SSA's ability to terminate payment of SSI benefits to inmates on a timely basis by providing incentive payments to State and local correctional facilities when they provide SSA with information that leads to termination of SSI payments.

CONCLUSION

In conclusion, Mr. Chairman, SSA takes seriously its obligations to those who need our programs, as well as to those who pay for them. That is why we have always maintained extensive program integrity, quality assurance, and entitlement safeguards. As I have outlined today, this is an ongoing process, as we constantly seek to enforce our zero tolerance rule for fraud.

Clearly, in a program as complex and as large as SSI, there is always work for us to do, and ways we can improve our stewardship of the program. But I am proud of the efforts we have already made. The agency looks forward to working with the Congress and the GAO to continue our efforts to ensure that those who are truly eligible for SSI receive it, while those who would defraud the program and the American taxpayer are tracked down, prosecuted and punished.

THE ERISA INDUSTRY COMMITTEE
WASHINGTON, D.C. 20005–3509
March 6, 1997

Hon. Nancy Johnson
Chairman
Subcommittee on Oversight
Committee on Ways and Means
11376 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Johnson:

We are writing in reference to testimony presented before the Subcommittee on March 4, 1997, by Patricia A. Dalton, Deputy Inspector General, U.S. Department of Labor, at the Subcommittee's hearing on "High Risk Programs Within the Jurisdiction of the Committee on Ways and Means."

In her testimony, Ms. Dalton recommended that legislation be enacted (1) to require full scope audits of employee benefit plans and (2) to increase reporting requirements imposed on plan administrators and plan auditors. The focus of this letter is the second recommendation—to increase reporting requirements.

Ms. Dalton notes that legislation to impose such requirements has been proposed in past years but never enacted. Indeed, the Pension Audit Improvement Act of 1995 (S.1490) received serious consideration in the last Congress.

S.1490, however, was not enacted because it was found to be overreaching, burdensome, and lacking fundamental safeguards appropriate in a free society.

We enclose for your information a statement that we filed with Sen. Nancy Kassebaum, Chairman of the Senate Committee on Labor and Human Resources about this bill last year. We also ask that this letter be included in the hearing record of your Subcommittee's March 4 hearing.

On behalf of The ERISA Industry Committee, we ask that such legislation not go forward, and would be pleased to meet with you to discuss our concerns at any time.

Sincerely,

JANICE M. GREGORY
Vice President

COPY

April 1, 1996

The Honorable Nancy Landon Kassebaum
Chairwoman, Committee on Labor and Human Resources
302 Russell Senate Office Building
United States Senate
Washington, D.C. 20510–1602

Re: The Pension Audit Improvement Act of 1995 (S. 1490)

Dear Madam Chairwoman:

We are writing to express our strong opposition to the Pension Audit Improvement Act of 1995 (S. 1490).

The ERISA Industry Committee (ERIC) represents exclusively the employee benefits interests of America's largest employers. ERIC's members provide comprehensive retirement, health care coverage and other economic security benefits directly to some 25 million active and retired workers and their families. Thus, we have a strong interest in proposals affecting our members' ability to deliver those benefits, their cost and their effectiveness, as well as the role of those benefits in the American economy.

The bill imposes new reporting requirements that are extraordinarily demanding, exceptionally vague, and unacceptably far-reaching. In combination, the bill's vague standards, tight deadlines, and severe penalties require reporting on the basis of suspicion and fear, rather than on the basis of known and verified facts. Legislation of this ilk is offensive and wholly inappropriate for any free society.

Contrary to its title, the bill applies to all employee benefit plans governed by the Employee Retirement Income Security Act ("ERISA"), not merely to pension plans. The bill includes draconian penalty provisions that apply even to plan administrators who innocently or mistakenly violate the bill's reporting requirements. The bill is clearly over-kill: it unnecessarily adds another layer of reporting obligations to the elaborate reporting and disclosure requirements of existing law and provides for the imposition of severe penalties on plan administrators who mistakenly or otherwise fail to comply with requirements that are both demanding and vague.

No hearings have been held on the bill in either the Senate or the House.

ERISA already imposes elaborate reporting and disclosure requirements on plan administrators. It requires the plan administrator to file an annual financial report, including an audited financial statement, with the Internal Revenue Service or the Department of Labor and to distribute a summary of that report each year to plan participants. ERISA also requires the plan administrator to distribute to plan participants a summary plan description and summaries of material modifications of the plan. In addition, plan participants have the right to examine, and to obtain copies of, all documents and instruments governing the plan.

S. 1490 would add a new § 111 to ERISA. As proposed, § 111 requires a plan administrator to notify the Secretary of Labor "within 5 business days after the administrator first has reason to believe . . . that an irregularity may have occurred with respect to the plan" (emphasis added). In addition, § 111 requires the plan's accountant to notify the plan administrator of an irregularity "within 5 business days after the accountant first has reason to believe that an irregularity may have occurred with respect to the plan" (emphasis added). Under the bill, if the accountant so notifies the administrator, the administrator is required to notify the Secretary of Labor within 5 business days. If the administrator fails to notify the Secretary of Labor within that 5-day period, the accountant must notify the Secretary on the next business day following the end of the 5-day period.

The bill defines "irregularity" broadly to include, among other things, any willful violation of ERISA's reporting and disclosure requirements and any intentional misstatement or omission of an amount or disclosure in a financial statement, accounting record, or supporting document undertaken to mislead.

The bill also requires the plan administrator to notify the Secretary of Labor within 5 business days after the termination of an engagement for auditing services; the notice must report not only the termination of the engagement but also the reasons for the termination. If there is a failure to report or if the accountant disagrees with the reasons given, the accountant must file his or her own report with the Secretary.

The bill provides that no accountant will be liable to any person for any statement made in good faith in a report required by the bill. However, the bill inexplicably fails to include a parallel provision protecting plan administrators from liability for the statements that they make in good faith in reports filed in accordance with the bill.

The bill gives the Secretary of Labor new authority to assess a civil penalty of up to $100,000 against any administrator who fails to file a report required by § 111. The Secretary also may assess a penalty of up to $100,000 against an accountant who fails to file a required report, but only if the failure is knowing and willful.

We oppose the bill on numerous grounds, including the following:

• Vague Reporting Standards. By requiring a report whenever the plan administrator or accountant has "reason to believe" that an irregularity "may have occurred," the bill establishes a standard that is unacceptably vague. The "reason to believe" standard appears to require a plan administrator to file a report whenever it might be deemed to have the slightest suspicion that an irregularity might have occurred. In view of the bill's tight reporting deadline and the harsh penalties that the bill provides for, plan administrators and accountants will be under enormous pressure to report matters that raise any potentially relevant concern, no matter how remote. For example, if a plan administrator suspects that there might have been a failure to comply with ERISA's reporting and disclosure obligations (no matter how insignificant the suspected violation might be), he or she will be pressured to conclude that there is "reason to believe" that an irregularity "may have occurred" even if he or she has no idea whether the failure was willful and even if he or she is uncertain whether the failure actually occurred.

• Unrealistically Tight Reporting Deadlines. The bill's 5-day and next-day deadlines are wholly unrealistic. They give both plan administrators and accountants insufficient time to gather additional facts, to consult with responsible individuals, to evaluate any facts that they are aware of, and to apply considered judgment to those facts. The bill promotes a "lynch-mob" mentality rather than thoughtful and accurate reporting.

• Draconian Penalties. The bill authorizes a penalty of up to $100,000 for each violation. While a $100,000 penalty is severe under any circumstances, it is absolutely draconian in view of the bill's vague reporting standards and unrealistically tight reporting deadlines. In combination, the vague standards and tight deadlines make it inevitable that plan administrators will inadvertently violate the bill's reporting requirements. What is worse, as explained below, the bill provides for penalties to be imposed even when a plan administrator acts in good faith and violates the requirements mistakenly or inadvertently.

• Penalty for Unwillful Violations. Although the bill provides for the imposition of penalties on accountants who engage in "knowing and willful" violations of the reporting requirements, the bill provides for penalties on plan administrators who fail to file any required report, regardless of whether the failure is knowing and willful. There is no justification for penalizing a plan administrator for failing to comply with a reporting requirement of this kind unless the failure is knowing and willful.

• Inequitable Treatment of Plan Administrators. As we have explained, the bill inexplicably allows penalties to be imposed on plan administrators for violations that are not knowing and willful, but provides for penalties on plan accountants only if the violation is knowing and willful. Similarly, although the bill immunizes accountants from liability for any statement made in good faith in a report filed in accordance with the bill, the bill fails to provide parallel protection for plan administrators. For example, if an accountant is terminated by the plan administrator, and the parties disagree over the reason for the termination, the accountant will be immune from liability for any statement it makes in good faith in a report filed with the Secretary of Labor, but the plan administrator will not receive parallel protection. This disparity in treatment is wholly unwarranted.

For all these reasons, we strongly oppose S. 1490. We will be pleased to meet with you to discuss our concerns in greater detail.

Sincerely,

MARK J. UGORETZ
President

Statement of the Health Industry Distributors Association on 'High-Risk' Programs

The following statement is submitted to the House of Representatives Committee on Ways and Means, Subcommittee on Oversight on behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA members provide value-added services to virtually every hospital, physician office, nursing home, clinic, and other healthcare sites in the country, and to a growing number of home care patients. As the intermediary between medical products manufacturers and Medicare providers, HIDA Members are able to provide unique "ground level" recommendations to aid efforts to combat fraud and abuse in the Medicare Program.

As a professional trade association, HIDA wholeheartedly supports the rigorous enforcement of laws that ensure that Medicare pays reasonable reimbursement amounts for medically necessary items and services on behalf of Medicare beneficiaries. HIDA has long advocated the responsible administration of the Medicare program, and has repeatedly identified specific abusive or illegal practices occurring in the marketplace to assist the government's anti-fraud efforts. HIDA has also assisted in the development of additional targeted policies designed to aid the government in the administration of the Medicare program. This statement will focus on two such policies, Medicare supplier standards and nursing facility consolidated billing.

POLICY RECOMMENDATION NUMBER ONE: SUPPLIER STANDARDS

To help rid the industry of the few illegitimate players which jeopardize patient care, tarnish the industry, and unfairly distort the market for medical products, HIDA urges the Health Care Financing Administration and Congress to require that all Part B suppliers comply with standards that will assure Medicare beneficiaries receive a consistent quality of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) services. The following recommended supplier standards result from a fundamental belief that the current Medicare Supplier Standards (42 CFR 424.57 et. seq.) are simply insufficient. Importantly, it is not just the de minimus nature of the standards that is deficient, but also the process Medicare uses to determine whether a provider actually meets those standards. The following recommended standards therefore would inject some substantive meaning into the notion of being a Medicare provider of DMEPOS services.

These new standards are intended to build upon those currently administered through the Medicare National Supplier Clearinghouse (NSC). These standards would therefore apply to all firms that have or apply for a Medicare Part B supplier number in order to provide DMEPOS services and bill Medicare on behalf of beneficiaries. They reflect the consensus of a wide array industry leaders, national associations, state associations, HIDA Members, and other constituent interests.

If the NSC adopts the recommended standards and changes the process by which it determines whether a provider actually meets the standards, Medicare will realize an immediate benefit by ensuring that beneficiaries receive DMEPOS items and services only from legitimate firms. If an effective screening process is used, unscrupulous firms will never have an opportunity to engage in abusive behavior because they will never be able to bill the Medicare program on behalf of beneficiaries. Consequently, the standards will significantly contribute to reducing fraud and abuse in the Medicare program. For these reasons alone, Congress should require HCFA to adopt these Supplier Standards.

Organization of Standards:

- *Basic Business Standards*—would apply to all firms applying for a Medicare Part B Supplier/Provider number and any firm that currently has a Part B supplier number issued by the National Supplier Clearinghouse.
- *Standards for Providers of Respiratory Products*—would apply to all firms providing respiratory products and services to Medicare beneficiaries, and billing Part B for those products.
- *Standards for Providers of Home Infusion Therapy*—would apply to all providers of home infusion therapy, and billing Medicare Part B for these products.

• *Supplier Enrollment/Application Procedures and Verification*—describes a new process by which suppliers would receive a Medicare Part B supplier/provider number. The process includes verification of information submitted to Medicare, and an on-site visit to the firm.

NOTE ON TERMS: Please note that the following terms are used interchangeably:

—patient, consumer, client

—supplier, provider

Basic Business Standards for Part B Suppliers

The Basis Business Standards would apply to all providers/suppliers that apply for a Medicare Supplier number, and that are in the business of providing medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries either in their home or in a nursing facility.

STANDARD BB–1: AS PART OF THE APPLICATION PROCESS, THE PROVIDER/SUPPLIER MUST PROVIDE BASIC INFORMATION, INCLUDING:

• Name

—A. Registration/business license

—B. D/B/A ("doing business as")

• Tax identification number

• Address verification

• Proof of insurance

—A. General product liability insurance

—B. Professional liability insurance (if company has health care professionals as employee(s))

STANDARD BB–2: Provider/supplier must comply with all federal, state and local regulatory requirements (e.g., licensure), and show proof of compliance when applicable.

STANDARD BB–3: Provider/supplier must provide evidence of financial soundness. May be demonstrated in many different ways, for example by:

—A. Bank references

—B. Insurance—property, liability

—C. Trade credit references

—D. Etc. (Dun & Bradstreet or other credit reports)

STANDARD BB–4: Provider/supplier must have policies and procedures to cover basic scope of services for appropriate product lines.

STANDARD BB–5: Provider/supplier must maintain all professional and business licenses and certifications, and show proof when applicable.

STANDARD BB–6: Provider/supplier must have 24-hour a day, 7 day a week service availability for appropriate products and response to emergency situations.

STANDARD BB–7: Provider/supplier routinely monitors the quality and appropriateness of services, equipment and supplies provided.

STANDARD BB–8: Provider/supplier has a corporate compliance program.

STANDARD BB–9 Provider/suppliers (owners and officers) shall not have been convicted of violations of Medicare and/or Medicaid rules and regulations.

STANDARD BB–10: Provider/supplier attests that it is knowledgeable of the Medicare laws, regulations and policies pertaining to the billing of the applicable services, equipment and supplies provided.

STANDARD BB–11: Provider/supplier has the capability (either directly or through contractual arrangements with other entities) to service customer locations, as evidenced by product inventory, distribution systems, and emergency backup systems.

STANDARD BB–12: Provider/supplier provides its customers with educational resources relative to the products and services provided such as assistance with understanding Medicare regulations, provision of Medicare's toll free beneficiary help line, equipment inservices (if applicable), and product information.

STANDARD BB–13: Provider/supplier has policies and procedure to document and resolve customer complaints and inquiries.

STANDARD BB–14: Provider/supplier maintains regular business hours.

STANDARD BB–15: Provider/supplier maintains a physical business location with its business name evidently displayed.

STANDARD BB–16: Provider/supplier has procedures to document maintenance and repair programs for equipment as applicable.

STANDARD BB–17 The patient/caregiver must be informed of the provider's compliance with all applicable HME Federal and State laws, regulations and Standards.

STANDARD BB–18 The provider/supplier must assure that all the necessary and appropriate patient/caregiver education has been provided or arranged for with respect to the services, equipment, and supplies provided.

STANDARD BB–19 The provider/supplier must provide patient/caregiver training in the safe and proper use of equipment, with a follow-up demonstration.
STANDARD BB–20 The provider/supplier must inform, in general terms, the patient/caregiver of his/her financial responsibilities.
STANDARD BB–21 The provider/supplier will assure that environmental considerations are addressed such that the continuing needs of the patient/caregiver are met in the safest possible manner.
STANDARD BB–22 The provider/supplier only uses equipment and supplies that conform to generally accepted industry manufacturing standards.
STANDARD BB–23 The provider must have a valid, current and accurate prescription for all equipment and supplies provided.
STANDARD BB–24 The provider/supplier must notify the prescribing physician of apparent patient non-compliance.

Supplier Standards for Providers of Respiratory Products

These provider standards would apply to providers of respiratory products (in addition to the Basis Business Standards described above).
STANDARD RESP–1: All patient/caregiver information must be kept in confidence (except when required to be released, for example, by JCAHO; and provider will first obtain client's permission).
STANDARD Resp–2: Providers may only provide respiratory therapy equipment for which it is an authorized dealer.
STANDARD Resp–3: The provider must perform and document scheduled in-home routine preventative maintenance of provider-owned (i.e., rental, loaner) equipment.
STANDARD Resp–4: Either directly or through contracting with another entity, the provider must perform and document manufacturers' scheduled maintenance of provider-owned (i.e., rental, loaner) equipment.
STANDARD Resp–5: Provider cleans, stores, and transports respiratory therapy equipment in accordance with the manufacturer's recommendations and all applicable Federal and local laws ad regulations.
STANDARD Resp–6: The provider must have a valid, current and accurate prescription for all respiratory therapy equipment dispensed.
STANDARD Resp–7: The provider must secure physician approval, either through a change in the prescription or through physician-approved protocols, before respiratory therapy equipment modality substitutions are made.
STANDARD Resp–8: The provider only utilizes the services of personnel who are appropriately trained, qualified, and competent for their scope of services.
STANDARD Resp–9: The provider utilizes services of health care professionals that adhere to all Federal and State laws, rules, and regulations.
STANDARD Resp–10: Providers providing life supporting or life sustaining respiratory therapy equipment assume the responsibility to directly provide or arrange for the services of a respiratory therapist or equivalent.

Supplier Standards for Providers of Home Infusion Therapy

These provider standards would apply to providers of home infusion products (in addition to the Basis Business Standards described above).

Performance Standards

STANDARD IV–1 Provider has competent staff:
A. Provider has trained, competent technical staff
B. Provider has access to qualified health professionals
STANDARD IV–2 Provider performs client assessments, which includes:
A. Appropriateness of therapy
B. Safety of home environment
C. Development of plan of care to establish product and service needs
STANDARD IV–3 Provider coordinates client care with other providers and practitioners:
A. Communication and interaction with other providers and practitioners
a. Patient assessment/service plan
b. Changes in patient's needs
c. Changes in patient's care regimen
STANDARD IV–4 Provider has a valid, current and accurate prescription for all products dispensed.
STANDARD IV–5 Provider schedules activities, including
A. Who does what and when
STANDARD IV–6 Provider performs patient/caregiver training which includes:
A. Indication for therapy

B. Administration of medications or formula
C. Operation and maintenance of pump
D. Inventory storage and management
E. Self-monitoring
F. Emergency response
STANDARD IV–7 Provider delivers, sets up and pickup equipment and supplies.
STANDARD IV–8 Provider performs ongoing monitoring and follow-up, including:
A. Assess response
B. Assess functioning of therapy delivery system
C. Assess product utilization, patient compliance
D. Assess continuing need for therapy (with others)
E. Equipment tracking, cleaning, maintenance and repair
STANDARD IV–9 Provider provides access to emergency response services:
A. Services are available 24 hours a day, 365 days a year
B. Provider responds within reasonable time
C. Provider provides intervention as indicated.
a. Technical
b. Clinical—provide instruction, visit or contact other provider
INFORMATION MANAGEMENT
STANDARD IV–10 Provider manages the following information related to the client:
A. Maintain clinical records
B. Patient satisfaction/grievances
C. Complications
D. Unscheduled deliveries and visits
E. Utilization data by service, by patient
F. Goals of therapy, patient needs

Application Process—for a Medicare Part B Supplier Number

The verification that a provider/supplier meets the Medicare supplier standards is vitally important to the provider/supplier industry, beneficiaries, and the Medicare Program to ensure that only viable providers/suppliers provide medically necessary DMEPOS items and services to Medicare beneficiaries.

HIDA recommends that non-governmental independent organizations verify that providers/suppliers comply with the Medicare supplier standards, both initially and on an ongoing basis. This recommendation is similar to the structure used world wide by the International Standards Organization (ISO). This process would be simple, minimize bureaucracy and paperwork, and most importantly, ensure the suppliers comply with the standards.

National Supplier Clearinghouse (NSC) would certify organizations that wish to verify suppliers meet the Medicare supplier standards.

• These organizations would verify compliance based solely on the Medicare supplier standards. Verification would include: A complete review of the application, Written follow-up on questionable areas On-site visit to verify/check remaining questionable areas.

• There would be a time limit to complete the review process (no more than 90 days).

• The provider/supplier pays the fee to the verification organization (a portion of which may go to the NSC to cover administrative costs).

• There would be a three year cycle for renewal of Medicare supplier number to ensure ongoing compliance with the Medicare supplier standards. The fee would cover the three year cycle.

Note: HIDA supports a reasonable application fee to cover costs of verification. The recommendation is made with the understanding that these verification procedures will actually weed out the "bad actors;" non-legitimate companies would not be able to get a Medicare supplier number because of the rigorous screening of all applicants.

POLICY RECOMMENDATION NUMBER TWO: NURSING FACILITY CONSOLIDATED BILLING

The Administration's FY 1998 budget package contains a legislative proposal prohibiting any entity other than a nursing facility from billing Medicare for the medical supplies and services provided to nursing facility residents. This "consolidated billing proposal" does not distinguish between reimbursements for services covered by Medicare Part A vs. Part B.

HIDA supports consolidated billing for nursing facility residents who are covered by Medicare Part A. We understand that Part A consolidated billing is needed to gather the information that the Health Care Financing Administration (HCFA)

needs to develop the nursing facility prospective payment system. However, HIDA believes that nursing facilities should retain their ability to use outside suppliers of medically necessary Part B services when the resident is not covered under the 100-day Part A stay. This choice is more efficient and economical for many nursing facilities.

Outside suppliers provide nursing facilities with a number of services that promote positive health outcomes. Value-added services provided by medical suppliers including storage, inventory management, clinical services (e.g., respiratory therapy, nutritional assessments, support for wound care protocols), billing and collection, and outcomes support. Many nursing facilities do not have the administrative staffing, physical space, or other resources to ensure that adequate quantities of the appropriate products are available to meet each patient's needs, especially since some patients require products on an emergency basis or have frequently changing needs. As a result, beneficiaries could be denied access to the wide range of high quality, medically necessary products that are currently available.

The Health Industry Distributors Association opposes consolidated billing for nursing facility residents who are not covered by Medicare Part A because:

Concerns Relating To Fraudulent Billing Are Not Applicable After The 100 Day Part A Stay: It is argued that consolidated billing is needed to eliminate the opportunity for fraudulent "double billing" of Medicare Part A and Part B. These concerns can be addressed through Part A consolidated billing—simultaneous billing of Part A and Part B is not feasible for residents who are not covered by Part A. In addition, the new Durable Medical Equipment Regional Carriers (DMERCs) have instituted tight controls over the Part B benefit. With full time Medical Directors developing and implementing strict guidelines defining medical necessity and utilization of medical supplies, the DMERCs have been highly effective in combating fraudulent billing practices. Therefore, irregularities in the Part B billings of outside suppliers providing services to nursing facility residents are readily apparent under the current system.

Consolidated Billing Would Impose New Cost Burdens On Nursing Facilities: By requiring fully consolidated billing, even when beneficiaries are not under a Part A stay, many nursing facilities that previously utilized outside suppliers to provide their residents with medically necessary supplies and services would be required to provide these services themselves, to directly bill for these supplies and services, and to assume other responsibilities that are currently fulfilled by outside suppliers. These responsibilities and services would add significant costs to a nursing facility. Importantly, current law allows a nursing facility to act as a Part B supplier; presumably those facilities who choose to do so now would continue this practice in the future if it is their best option.

Consolidated Billing Is, At Best, Budget Neutral: The proposed legislative prohibition against the use of outside suppliers is considered revenue neutral, as it is characterized by the Congressional Budget Office as a billing requirement. In reality, fully consolidated billing would likely increase costs to the health care system, since the supplier community provides valuable billing expertise, inventory control, staff education and clinical services which the facilities will need to replace.

Consolidated Billing Is Not Necessary For Prospective Payment: It is argued that consolidated billing is necessary to collect the data needed to construct a prospective payment system for nursing facilities. However, there is no prospective payment proposal for the Part B benefit, which will continue to exist unless Congress specifically eliminates it.

CONCLUSION

HIDA appreciates the opportunity to submit these recommendations to the Subcommittee. We urge Congress and HCFA to strengthen the Medicare program by implementing rigorous supplier standards and requiring nursing facility consolidated billing during the 100-day Part A benefit. These two recommendations will aid in the ongoing effort to combat Medicare fraud and abuse while promoting the provision of consistent, high quality services to Medicare beneficiaries.